06-06698 Valerie Byrdsong

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

,,,,,,		I- For State Registrar	Certificate	of Death	,,,	Reg N	. 200	5 2000
Physicia	ın/	Decedent's Name (First, Middle,Last)			Mon	e of Death oth Day	y Year	30 time of Dean 100
ledical Exami		Valerie Byrdsong			Sep	tember 6,	2006	
and the same of th		4a. Facility Name (if not institution, give street and number)		4b City, Town, or Location Baltimore	of Death		4c County of Death	
		1024 Radnor Avenue			- Odllas IO De	to of Dight (14)	n/a M/DD/YYYY) 9 Birt	hplace (State or
Funeral Director		5. Social Security Number 6. Sex 7. Age 1 M 2 X F	(In yrs last birthday	Yrs. If Under 1 Year If Under		11/15/19	Foreig	
· ·	F	Usual Residence of Decedent 10a State 10b County 1	0c. City, Town or Li	ncation		_		10d. Inside City Limits
w any		MD n/a	Baltimore					1 X Yes 2 No
daryland 28a-f show	ģ	10e. Street and Number		10f. Zip Code		10g C	Citizen of What Cour	
Man r 28a	Director					109		,.
th the 23a o		1024 Radnor Avenue 11. Marital Status 12. Was Decedent E	wor in HS 13	21212 Was Decedent of Hispanic Or	igin? (Specify Y	es or No.	USA	can Indian, Black,
ath wi	uneral	1 X Never Married 2 Married Armed Forces?		If Yes, specify Cuban, Mexica			White, etc.	
er de	뜨	3 Widowed 4 Divorced If Yes, Give Year	X No	Yes 2 X No specify	<i>r</i>		Specify Black	
urs afi tural'	a p	15. Decedent's Education (Specify only highest grade comp		edent's Usual Occupation (Give		ne 16b	o. Kind of Business/li	ndustry
72 hor	ete	Elementary/Secondary (0-12) College (1-4 or 5-	-) durir	ng most of working life. DO NO	I use retired)			
5-0036 fled within 721 Hygiene 1 other than "the Medical E	Completed	12th unknown		occupation			altimore Cit	У
5-0 filed v Hygir I othe		17. Father's Name (First, Middle, Last)		1	er's Name (First,		en Surname)	
2121 buld be fil Mental I marked ic event.	o Be	James Byrdsong 19a Informant's Name/Relationship (Type, Print)	19h M:	ailing Address (Street and Nu	llie Smit		City or Town State	Zip Code)
O 8 2 2 €	ř	Sheldon M. Caudle / Brother	9013-4	Majors Lane; Col	umbia, MD	21045	4.0, 2.1.1.1, 2.1.1.1	
		20a Method of Disposition		sposition (Name of cemetery,	Date	20	c. Location - City or	Town, State
0 0 0 -		1 Burial 2 X Cremation 3 Removal from State	e Metro Cre	or other place)	09/15/20	06 R	altimore, Ma	arvland
Baltimo permit Pag Department Important: Injury or of		4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee	TRECTO CIT	22. Name and Address of Facil		meral I	Home PA.	it y faild
Balti permit Departm Imports injury o	1	Limerta Jones	1	638 N. Gilmor Str	eet; Balt	imore, 1	MD 21217	
Physician		23a Part I. Enter the disease, or complications that caused t failure. List only one cause on each line.	he death. Do not er	ter the mode of dying, such as	cardiac or respir	atory arrest,	shock, or heart	Approximate Interval Between Onset and
/Medical Examiner	3 7		hythmia due	to myocardial fil	prosis			Death
Xansinoi		or condition resulting in death) Due to (or as a conse	quence of):					
	<u>.</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a conse	quence of).					
	E.	Cause. Enter Underlying Cause						
cuted and transit	Examiner	events resulting in death) Last Due to (or as a conse	quence of)					
N	ledical	X UNPENDED AMENDED #23	- 07 ME	-000 10/01/00 TT	P.			
760, icate be ew	led	IF FEMALE: 23c. If yes, outcom		g862, 12/21/06 T	L		23d Date of delivery	/
	M/u	23b. Was decedent pregnant in the past 12 months?	2	Fetal death 3 Ector	oic pregnancy		Month [Day Year
Box 68's death certificate attending	/sician/	4 Pregnant at 1	ime of death 5	Other (Specify)				
O. B(trthe de by the a	Phy	Part II. Other significant conditions contributing to death	but not resulting in	the underlying cause given in f	Part I 2	3e. Did tobac	co use contribute to	the cause of death?
Accords, P.O. Box 68' The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	b	Turing Sullar organical actions and the actions of the action of the actions of the action of the actions of th	241110111	,	191	1 Yes 2	No 3 Prof	bably 4 🗸 Unknown
ds, equire	ompleted				2	4a Wasan		itopsy findings available
COL law n has b	nple	<u> </u>	- · 			autopsy performed	d? death?	completion of cause of
tal Rec rian: The l certificate l	Co			26 Place of Deat			No 1 Y	es 2 No
Vital ysician: nis certif	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatie	nt 2 ER/Outpa	Other	Nursing Hom	-	sidence 6 V Othe	r; Scene
n of Vital Records, hing Physician: The law requir After this certificate has been s funeral director, page 2 should b	٠ <u>.</u>	27. Manner of Death 28a Date of Injur	y 28b. Tim	e of Injury 28c. Injury at Wo	rk? 28d. [injury occurred	
C = 7 3	ertification:	1 X Natural 5 Pending (Month, Day.Yo	ear)	1 Yes 2	No			
Division tal or Attendii rs after death al Director: A	ficat	Accident Investigation Suicide 6 Could not be 28e. Place of Inj	ury - At home, farm,	street, factory, office building				ural Route Number, City
DIVI pital or ours afte eral Dir	erti	3 Suicide 6 Could not be determined (Specify)			0	r Town, State	*)	
Division of Vital File Hospital or Attending Physiciau: Pin 24 hours after death the Funeral Director: After this certifin apletely filled in by the funeral director.	alc	29a. Certifier 1 Certifying Physician: To the best of my	knowledge, death	occurred at the time, date and	place, and due to	the cause(s)) and manner as star	ted
Division To the Hospital or Autem within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Examiner: On the basis of examiner and manner stated	nination and/or inve					
. , , , ,	Ž	29b. Signature and title of certifier		29c. License numbe	er		3d Date signed (Mo	
		Thiode M. First In.	n. N.	O.C.M.E.			September 7, 20	100
		30 Name and address of pers 1 who completed cause of d	eath (Item 23a) edical Examine	er 111 Penn Street, B	Saltimore Mr	21201		
			's Signature	a Fill Gill Otteet, L				
S Regis			No An					

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene **Edward Bogat** 29002 2006 Certificate of Death Reg No Registra 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day September 9, 2006 1825 hrs BOGAT Medical Examiner **EDWARD** 4b. City, Town, or Location of Death 4c County of Death 4a Facility Name (if not institution, give street and number) Baltimore Maryland General Hospital N/A 8 Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs last birthday) 5 Social Security Number **Funeral** Foreign Months Hours Director CountrUKRAINE 218-29-1583 .2/12/1975 1 **X** M 30 Usual Residence of Decedent 10d Inside City Limits 10c City, Town or Location 10a. State any 1 Yes 2 X No BALTIMORE or 28a-f show MD BALTIMORE Director 10g Citizen of What Country's 10f. Zip Code 10e. Street and Numbe 21209 U.S.A. 6605 CHELWOOD ROAD 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces's 2 X Married Never Married 2 X No Yes Divorced If Yes, Give Year 1 Yes 2 Y No specify Specify WHITE other than "natural", the Medical Examiner ð 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) leted Elementary/Secondary (0-12) College (1-4 or 5+) ANTIQUE RESTORER MD 21215-0036 12 ANTIQUES Compl permit Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thin jury or other traumatic event, the Medialury events are supplied to the contract of the medialury events and the contract of t 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) TAMARA SHORNIKOVA BOGATYRYEV Be YAKOV 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 6605 CHELWOOD ROAD - BALTIMORE, MD 21209 YANA BOGAT / WIFE 20c. Location - City or Town, State Place of Disposition (Name of cemetery, 20a Method of Disposition Baltimore, crematory or other place) X Burial Cremation 3 09/12/2006 REISTERSTOWN, MD BALTIMORE HEBREW CONG. Donation 5 Other Specify Signature of Funeral Service Licensee 22 Name and Address of Facility SOL LEVINSON & BROS., INC. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shock, or heart LE Ap M im 21200 failure. List only one cause on each line **Physician** /Medical Mixed Drug Intoxication (Ethanol, oxycodone, cocaine) Immediate Cause (Final disease xaminer Due to (or as a consequence of) or condition resulting in death) Sequentially list conditions Due to (or as a consequence of) ner if any, leading to immediate cause. Enter Underlying Cause Exami (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and ian/Medical X UNPENDED AMENDED nttending physician or use as the burial item#23a,27,28a-f, G859,9/27/06 TT Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 9 Unknown 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 Yes 2 No 3 Probably 4 V Unknown Completed s been s 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy performed? death? certificate has 2 No ✓ Yes 2 No 1 🗸 Yes 26 Place of Death (Check only one) 25 Was case referred to medical Be Other₄ examiner? DOA Nursing Home 5 Residence 6 Other 2 V ER/Outpatient 3 Inpatient this ပ 1 🗸 Yes 28c. Injury at Work? 28d Describe how injury occurred 28a Date of Injury (Month, Day, Year Manner of Death 28b Time of Injury Certification: Natural Yes 2 X No 5 Pending FNd 9/9/2006 Fnd 5:30 pm unk 24 hours after death Funeral Director: Accident Investigation 28f. Location (Street and Number or Rural Route Number. City or Town, State), 861 North Howard Street Baltimore, 28e Place of Injury - At home, farm, street, factory, office building, etc. Suicide 6 X Could not be determined (Specify) unk Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier September 10, 2006 O.C.M.E. me and address of person who completed cause of eath (Item 3a) 1 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Zabiullah Ali, M.D. 31 Date filed (Month, Day, Year) State 2006 SFP 13 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2006 1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Rason **Physician** 2006 0 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Sandtown Winchester Facility Future Care 8. Date of Birth (Month, Day, Year) 11/08/1910 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🗓 F Days Hours 95 Yrs. 246-30-1658 Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. fnside City Limits or 28e-f ehow the Medical Examiner must be notified at 1 KYes 2 No Director MI timore 10e. Street and Number W. Mt. 10g. Citizen of What Country? 10f. Zip Code Royal Itame 23a 21217 WHE Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 "naturel", or 1 Yes 2 No Specify: Specify: δ 3 ☑ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: if liem 27 is marked other then 'any injury or other treumatic event, the Me any injury or other treumatic event, the Me any singer. Elementary/Secondary (0-12) College (1-4or 5+) Aid. ursing Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Maggie Cheery James Gorham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) White 3374 Brighton St. Adtimore MD 21216 Sister) .OBa 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Park 09/12/2006 Pandallstown MD 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Funeral SVC Vaughn C. Greene Funeral SVC 5151 Balto North Pike Baltin 21. Signature of Funeral Service Licensee augh Pike Baltimore Treone MD 21329 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failly. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) and ovas 100 clas Physician /Medical Due to (or as a consequence of) Examiner 0 Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Examine The law requires that the death certificate be executed burial-transli n cer Due to (or as a consequence of Box 68760 attending physicien ician/Medicai use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day ģ in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) P.O. the detached Physi 9 Unknown 9 Unknown ģ been signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 1 10 24a. Was an page 2 s has autopsy certificate 1 Yes 2010 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No P 1 🗌 Yes this ctor: After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Division Hospitel or Attending Maturaf 5 Pending Injury 1 ☐ Yes 2 ☐ No thin 24 hours after death. 2 Accident investigation 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 405 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eyew St. Baltime 32. gistrar's Signature 31. Date filed (Month, Day, Year) State SEP 1 3 2006

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 29004 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** CASSIDY BESSIE MAE otember 5 2006 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ba NA tealthca MORE If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) If Under Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** Days Hours 1 ☐ M 2 🗷 F 215. 24. 432 84 05-12. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f ehov 1 Nes 2 No Director BALTIMORE MD N 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 503 STREET N. DENISON 21229 USA by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗖 No ö 1 ☐ Yes 2 🖪 No Specify: If Yes, Give Year or Dates: Specify: BLACK 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) r then Elementary/Secondary (0-12) College (1-4or 5+) NURSES ASSISTANT STATE OF MARYLAND 8/14 GRADE NIA 27 is marked other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be of Heelth and Mental H Hem 27 is marked of r other treumatic ever PRINCE HUMPHREY MAGGIE MYERS 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ST. VANESSA CASSIDY 503 N. DENISON BALTO, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If It eny Injury or o once. 1 Burial 2 □ Cremation 3 □ Removal from State 09-11-06 4 Donation 5 Other (Specify) MT. XION BALTO. MO 21. Signalure of Funeral Service Licensee 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE Vaushn 5151 BAUD. NATE PIKE BAUD. MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition BOWEL OBSTRUCTION Priysician resulting in death) /Medical INKNOWN Examiner BOWEL 15 CHEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): ettending physicien end I for use as the burial-transit Exam Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate hes director, page 2 s autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) determined 4 Homicide within 24 hours at To the Funerel Di completely filled in 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar

DHMH 17 Rev 1/2001

EP 0

Pages 1 and 2 should be filed within 72 hours after nent of Heelth and Mental Hygiene.

Baltimore, Maryland 21215-0036

Records, P.O. Box 68760,

Division of Vital

the Hospital

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

rea

MARIES

32. Registrar's Signature

CURTIS

ST AGNES

29c. License number

DU051865

HOSPITME

29d. Date signed (Month, Day, Year)

BALTIMERE

SEPTEMBER 5, ZOOK

MU

State of Maryland / Department of Health and Mental Hygiene 2006For State Ragistra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** September 9, 11:26 A M Albert W. Clark, III 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 9301 Snyder Lane Perry Hall | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Min. | May 27, 19 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 XM 2□ F 72 217-30-3517 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County th and Mental Hygiene. 27 is marked other than "naturel", or iteme 23a or 28a-1 ehov treumstic svent, the Medical Examinar must ke notified all 1 ☐ Yes 2 🕱 No Maryland Baltimore Perry Hall Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21128 U.S.A. 9301 Snyder Lane Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 🖄 Yes 2 🗆 No
If Yes, Give 1954 – 58
Year or Dates: Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Front End Manager Grocery Store 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Albert W. Clark, Elizabeth Hires 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Catherine Sanders 9301 Snyder Lane, Perry Hall. MD 21128 (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Parkwood Cemetery 9/13/2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licenses 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final · Arterio sclerotu Physician disease or condition resulting in death) /Medical Due to (or as a consequence ol): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a Wasan 1 Yes 2 No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Certification: To 1 Yes 2 No 28c. Injury at Work? 28a. Date of tnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending within 24 hours efter death.

To the Funeral Director: All completely filled in by the fu 1 Yes 2 No investigation 6 Could not be determined 28l. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of tnjury - At home, farm, street, lactory, office building, etc. (Specify) 4 - Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29b. Signature 173 title of certifier belief M Soptem ber 122006 14-10 30. Name and address of person who completed cause of death (1em 23a) (Type, Print) CT. Luther ville, M.D. Trimble 31. Date filed (Month; Day, Year) 32. Prigistrar's Signature State 2006 Registrar

ciar lica ine	1, Decedent's Name (First,				Cei	rtificate	e of L	eatn			Reg. No	lUb	29006
lica		liddle, Last)							2. Date of De	ath Day	Year	3. Time of Death
	7// HKL // ^	,			CRI-	TES					BER II.		1613 PM
ıψ	A. Carlle Alexan (Mark Land	ution, give	street and number	r)		4b. City,	Town, or l	Location of	f Death		4c. Coun	ity of Death	
	NORTHWE	7	ITO SPITAL					LLST				tetim	ORE
	5. Social Security Number	6. Se	X 7.7		last birthday)	If Under Months		If Under 2 Hours	Min.	8. Date of Bir (Month, Da	th y, Year) 1/1958	9. Birthp	place (State or Foreign
	220-72-063 Usual Residence of Decede		E	4	7 Yrs.					09/24	/1958		WV
	10a. State 10b. Co			10c. Ci	ty, Town or Lo	cation							IOd. Inside City Limits
1	MD An	. ο λ <i>γ</i>	undel		Pasade								1 ☐ Yes 2 No
Director	10e. Street and Number	ie Ai	under	1	rasaue	10f. Zip	Code				10g. Citizen o	1 What Cour	
		- D-						_					my:
Lingral	8538 Neptu	ie Dr	12. Was Deceder	nt Ever in Li	15 13		1122		nin? (Sne	acify Vas or No	U.S.	A . ace - Americ	ean Indian
1 5	1 Never Married 2	Married	Armed Force	s?		f Yes, spec	rty Cuban	, Mexican,	Puerto	ecify Yes or No Rican, etc.)	BI	ack, White,	
7			If Yes, Give Year or Dates			1□Yes 2	No No	Specify:			Spec	ity: Whi	+0
		dent's Edu	ucation		16a. Dece	dent's Usua	l Occupat	tion			16b. Kind of		
Completed	(Specify only I		de completed) College (1-4a		(Give	kind of wor. D O NOT us	rk doné du e retired)	ıring most	of worki	ing			,
8	5 12	2)	College (1-40	r 5+)	Break	: & S	hear	r Op	era	tor	Shee	t Met	cal
0	17. Father's Name (First, Mi	dle, Last)						-		(First, Middle,	Maiden Suma	ame)	
A OF		or C	Crites					Car	rie	Bell	West		
۲	19a. Informant's Name/Rela	ionship (T)	ype, Print)		19b. Mailir	ng Address	(Street an	nd Number	r or Rura	I Route Numbe	er, City or Town	n, State, Zip	Code)
	Merlin Cri	es /	/ Father	r						, Pasa			
	20a. Method of Disposition			20b. F	Place of Dispo	sition (Nam	ne of	T	4	ate	20c. Location		
	1 ☐ Burial 2 🔏 Crema 4 ☐ Donation 5 ☐ Oth			6	cemetery, crer 237 i A37	•		·	0 / 1 ′	3/06	Do 1+1	moro	MT
	21. Signature of Funeral Se			Pay									Home, PA
	1	1			1								21122
	23a. Part1. Ent - the diseas shock, or reart failure: Immediac Cause (Final disease or condition resulting in death)	a, or compl List only o	ne cause on each	edn	th. Do not ent	er the mode	of dying,	such as c					Approximate Interval Between Onset and Death
10	Sequentially list conditions,		b. Out to (or t	who is a suiseu	**								or of their
dical Examiner			Due to (or a		ol as juence of):	busi							urknown
Physician/Mer	IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 Yes 2 No 9 Unknown	2	23c. If yes, outcom 1 □Live birth 4 □ Pregnant 9 □ Unknown	2 Feta	Ideath 3	Ectopic pre						ate of deliver	ery Day Year
by P		ditions co	ntributing to death	but not res	ulting in the u	nderlying ca	use given	in Part I.		23e. Did to	obacco use cor	ntribute to th	ne cause of death?
E P	respirator	2 A	Cailere							1 🗆 🕆	res 2□No	3 🗌 Prob	ably 4 DUnknown
Completed		g <i>V</i>								24a. Was autor perfo 1 🗆 Yes	an 24b osy med? 2X No	. Were auto prior to cor death? 1 ☐ Yes	psy findings available impletion of cause of 200 No
a	25. Was case referred to me examiner?	_	V.III.							Check only o			
	1 ☐ Yes 2 No	,	lospital: 1 Mnpa		ER/Outpatien		A Other	4 Nur	sing Hon	ne 5 ☐ Resid	dence 6 🗆 Ot	ther (Specifi	v)
Certification:	27. Manner of Death 1 Natural 5 Pr 2 Accident in 3 Suicide 6 C	nding estigation uld not be	28a. Date of In (Month, L		28b. Time of Injury	М	3c. Injury a Work? 1 ☐ Ye	at es 2⊡N	lo 2	28d. Describe t	now injury occu	ırred	
PITITION	4 Homicide	emined	28e. Place of I building,	njury - At ho etc. <i>(Specif</i>	ome, farm, str (y)	eet, factory,	office		2	28f. Location (S City or Tox		ber or Rura	I Route Number,
		fying Phys cal Exami	sician: To the bes ner: On the basis and manner:	of examina	owledge, death	occurred a restigation,	it the time in my opir	, date and nion, death	place, a	and due to the	cause(s) and m date and place	nanner as st	ated. the cause(s)
edical	D					200	License r	numbar			29d. Date sign		D V)
Medica	29b. Signature and title of ce	tmer ,				250.	Cicense I	Idilibei			250. Date sign	ed (Monta,	Day, rear)

Registrar

State

SEP 1 3 2006

		-	1 - For State Registrar	State of Mar	•		of Health a of Death	nd Mental Hy	giene Reg. No 2006	29007
	Physici	_	1. Decedent's Name (First, Middle, La	1				2. Date of De. Month	Day Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give	e street and number)		4b. City, Tov	wn, or Location of	Death	8 & OOG 4c. County of Dea	
	Examin	er	8161 PARKhai	0			DENDALI		BALTI	
	Funeral Director		182-14-3093	6ex 7. Age (In yrs. last birthday Yrs.	Months D	ear If Under 2 lays Hours	Min. 8. Date of Bin (Month, Da		thplace (State or Foreign
	-fahow fied at		Usual Residence of Decedent 10a. State 10b. County 10b. County	Mori	10c. City, Town or L	ocation STPCIN	7			10d. Inside City Limits 1 ☐ Yes 2☐ No
1	a or 28e	Direc	10e. Street and Number 8:42 EASTDALE	c RD		10f. Zip Co	21324	,	10g. Citizen of What Co	
36	Perfilt. Pages I and 2 should be filled within 72 hours after been with the maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if team 27 is marked other than "natural; or itema 23a or 28e-f ahow any Injury or other treumatic avant, I.a Medical Examinar must be notified at 20cs.	by Funeral Director	11. Marital Status 1 Never Married Marned 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Des 2 No If Yes, Give Year or Dates:	U-5	Was Decedent If Yes, specify	t of Hispanic Orig Cuban, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)		erican Indian,
21215-0036	Minin /z nou ne. han "natura e Medical E	Completed	15. Decedent's E(Specify only highest gr	ducation ade completed) College (1-4or 5+)	16a. Dec (Giv life.	DO NOT use r	tone during most	of working	16b. Kind of Business	·
nd 2	Mental Hygiene arkad other tha	To Be Co	17. Father's Name (First, Middle, Last	NA		Fronci	18. Mother	's Name (First, Middle)		
Mary	and z should a ealth and Men! n 27 Is marked		19a. Informant's Name/Relationship	(Type, Print)	19b. Mai		treet and Number		er, City or Town, State,	
nore,	Pages I and nent of Health snt: If Item 27 ury or other tr		20a. Method of Disposition Burial 2 Cremation 3 4 Donation 5 Other (Speci	Removal from State	20b. Place of Disposemetery, criticals	osition (Name matory or other	of	Date	20c. Location - City or Roselale	Town, State
	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Lice				Address of Facility	neral Home D. Balto M.	PA 31034	1 43
	hysician	Ĺ	23a. Part1. Enter the disease, or con shock, or heart failure. List only transdiate Cause (Final disease or condition	polications that caused the one cause on each line.	ne death. Do not e					Approximate Interval Between Onset and Death
,160,	Medical whicien and whicien and white parial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Renew Due to (or as a	consequence of):	Ce	ncen			
.O. Box 68	requires met me death certificate een signed by the attending phys hould be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death 3	□Ectopic pregi □ Other (speci			23d. Date of de Month	livery Day Year
rds, P.	quires thet to in signed by uld be detac	ed by Ph	Part II, Other significant conditions	contributing to death but	not resulting in the	underlying caus	se given in Part I.		obacco use contribute t Yes 2 No 3 P	o the cause of death?
I Rec	Ine law ate has b page 2 sl	Completed						24a. Was auto perfo 1 🗆 Yes	ormed? death?	utopsy findings available completion of cause of s
Vital	Physician: this certific rat director.	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	t 2 ER/Outpati	ent 3 DOA	Othor	of Death Check only o	dence 6 Other (Spe	poity) Henre
Division of	To the Hospitel or Attending Physician: Inin 24 hours elfer death To the Funeral Director, Affer this certific completely filled in by the funeral director.		27. Manner of Death J- Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day			Injury at Work?	28d. Describe	how injury occurred	(10.10
Divis	s efter de s efter de sl Directo ed in by th	Certification:	3 Suicide 6 Could not 4 Homicide determined		y - At home, farm, s (Specify)	treet, factory, o	office	28f. Location (City or To	Street and Number or Fi wn, State)	lural Route Number,
:	n 24 hour n 24 hour ha Funera	edical	29a. Certifying P (Check only 2 Medicat Exa	hysician: To the best of miner: On the basis of e and manner state	examination and/or	ith occurred at nvestigation, in	the time, date and my opinion, deat	d place, and due to the hoccurred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the comp	Σ	29b. Signature and title of certifier				icense number		29d. Date signed (Mon	th. Day, Year)
	6		30. Name and address 1 person who	completed cause of dea	ath (Item 23a) (Type	o, Print)	52069 5- Paul	2 40	Rulto W	7.
10.34	Sta	ite ar	IRA E 14AV 31. Date filed (Month, Day, Year) CFP 1 3 2	32 Aegistrar	's Signature	solls?	med	PX.	Rulto 12	21505

		•	For State Registrar	State of Maryland		tment of H ificate of L			ene200(5 29008
	Physicia		1. Decedent's Name (First, Middle, Last)	. CARU.	50			2. Date of Death Month	Day Year	
	/Medic Examin Funeral Director		4a Facility Name (If not institution, give some solution). Give 5. Social Security Number 6. Security Number 15. Usual Residence of Decedent	al Center	ast birthday) Yrs.	4b, City, Town, or SA (T If Under 1 Year Months Days	Location of Death MO V If Under 24 Hrs. Hours Min.		4c County of De	ath JMUNE inthplace (State or Foreign Country) lermo, Italy
	ed at	20	10a. State 10b. County MD Balti		, Town or Loc	ation				10d. Inside City Limits 1 ☐ Yes 2 ▼No
	h with the N 23a or 28a-f	Funeral Director	10e. Street and Number 2101-A Creek R	oad		10f. Zip Code 2121	9	10	g. Citizen of What (Country?
980	within 72 hours after deeth with the Maryland liene. rthen "natural", or items 23a or 28a-f ehow the Medical Exemitier night be mutified at	þ	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Sey Yes 2 □ No Arm If Yes, Give Year or Dates: WWII	Y 13. W	as Decedent of H Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race - An Black, Wh Specify: W]	
21215-0036	within ne. hen	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0·12) 8th		(Give k	O NOT use retired	during most of work	king	6b. Kind of Busines Seafare	rs Int'l
land 2	be filed stal Hyg od othe event,	To Be C	17. Father's Name (First, Middle, Last) Philip Caruso					ine (First, Middle, M		
Maryland	12 should hand 7 ie m		19a. Informant's Name/Relationship (T) Anna Santavene		1	,			City or Town, State	
Baltimore,	Pages 1 end 1 ment of Health ant: if item 27 ury or other tr		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F Donation 5 □ Other (Specify)	Removal from State	emetery, crem	ition (Name of atory or other place nislaus	u / 1 h		altimore	·
Balt	permit. Pag Depertment Important: i eny injury o		21. Signature of Funeral Service Licens	omino D		Name and Address	onkling	seph N. St. Ba	Zannin ltimore	o Jr.FH , MD 21224
	Physician /Medical Examiner	er	23a. F. htt. Enter the disease, or popply nock, or heart failure. List only of Immr-liate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	ications that caused we death ne cause on each line. a	MTC sence of):	r the <i>m</i> ode of dyin	DJUM DJUM 5CULW	or respiratory arre	ty Case	Approximate Interval Between Onse and Death ON
,0928	icete be executed physicien and	dical Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent).	uence of):	JEN.	AL F	PATCI	INE	/week
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Δ.	quires that n signed b uld be deta	Þ	Part II. Dther significant conditions co	ntnbuting to death but not resu	ulting in the un	derlying cause giv	ren in Part I.		acco use contribute s 2 □ No 3 □	to the cause of death? Probably 4 Denknown
Vital Records,		Completed						24a. Was ar autopsy perform 1 Yes 2	24b. Were prior to death	autopsy findings available to completion of cause of ? es 2 No
Vita	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	SD/Outsatiss	act pos Oth	AC.	th (Check only one		anniel.
ō		on: To	1 Yes 2 No 27. Manner of Death t Natural 5 Pending	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injur	y at	28d. Describe ho	nce 6 Other (Si w injury occurred	рөспуј
Division	l or Attendin efter death. Director: Aft I in by the fur	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stre		Yes 2 □No	28f. Location (Str City or Town	reet and Number or , State)	Rural Route Number,
	To the Hospital or Attending within 24 hours effer death. To the Funeral Director: Affer completely filled in by the fune	edical Ce		rsician: To the best of my kno iner: On the basis of examina and manner stated	wledge, death tion and/or inv	occurred at the til	me, date and place	, and due to the ca erred at the time, da	use(s) and manner ate and place, and c	as stated. due to the cause(s)
	To the within ! To the comple	Med	29b. Signature and title of certifier	10.11.01.31.00.	_m	29c. Licens	se number	29	od. Date signed (Mo	onth, Day, Year)
	10+1		30. Nam-a address of person who d	ompleted cause of death (Item	23a) (Type, I	Print) // A //	F RAI	TIMA	UF MI	2/2/2
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	- IVII	00-00-1	- FILVI	, , , , ,	PIPUS
0.1	Regist	ar	SEP 1 3 20	06 Bloques A	Cr Ago			172 5 5 50 5		

State of Maryland / Department of Health and Mental Hygiene 2005 29009 1 - For State Registrar Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day September 08 2006 7:00 PM **Physician** ovidson \mathcal{M} . Harrer /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE SAINT AGNES HOSPITAL If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Days Months Hours 1 № M 2 🗆 F MD 215-30-8558 02/03/1935 Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State r than "natural", or itams 23a or 28a-f show the Medical Examinar must be notified at 1 X Yes 2 No Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21730 Funeral filed within 72 hours atter death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status 1 □ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify If Yes, Give Year or Dates: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) LPN Medica Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fit and Mental H Selethia Slater Harvey M. Davidson SR Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) t of Health a (wife) Baltimore MD 21229 Selma 113 Wicklow Rd Davidson Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State ö permit. Page Depertment of Important: If any injury or once. 09/13/2006 Baltimore, MI Cenetery 4 ☐ Donation 5 ☐ Other (Specify) Westeen 22. Name and Address of Facility Vaughn C. Greene Funeral Eve Vaughn C. Greene Funeral Eve 5151 Batto Nati Pike Battimore MD 21229 21. Signature of Funeral Service Licensee Vaugho C Greene 23a. Part 1. Enter the tise ase, or complications that caused the death. Do not enter the mode of dying; such as cardiac or respiratory arrest, shock, or heart failtire. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) one month Dneymonia **Physician** /Medical Due to (or as a consequence of): 2 years Examiner gestive Heart Failure duito Aortics Unisi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner physicien and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the as attending i 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4☐ Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No o 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan autopsy performed 1 Yes 2 No certificete Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 to this ierai Diractor: After the filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Attanding 1 Matural 5 Pending 1 Yes 2 No death. investigation 2 Accident within 24 hours efter death To the Funeral Director: completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier POJHAN MO September 08 2006 PAYAM P20283 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD 21229 PAYAM PSJHAN, 900 CATON Ave 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

MARVE

ORIGINAL

			, For	State of Man	yland / De _l		Health and	•	giene	0.00010
			1 - State Registrar		C	ertificate of	Death	2. Date of Dea	Reg. No. 2	0.6 29010 3. Time of Death
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) ROXIE DAVIDSO	7				Month O9	Day	Year 2006 0547 AM
	Examin		4a. Facility Name (If not institution, give str UNIVERSITY OF MARY LAN		CONTEN	4b. City, Town,	or Location of D	eath	4c. County of	
	Funeral		5. Social Security Number 6. Sex	7. Age (I	n yrs. last birthda	-	r If Under 24 I	Hrs. 8. Date of Birt		Birthplace (State or Foreign Country)
	Director		216-72-3229 Usual Residence of Decedent	W 200F	50 Yrs.			July 21		AM
9	ehow det	_	10a. State 10b. County	10	Oc. City, Town or	Location				10d. Inside City Limits 1 ☐ Yes 2 🗷 No
40.44	28a-f	Director	Maryland How 10e. Street and Number	ard		10f. Zip Code	Elkridge		10g. Citizen of W	
4	238 or	rai Di	6511 Arrow Way				2107			U.S.A.
700	items inerms	Funerai	11. Marital Status 12 1 Never Married 2 Married 12	 Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No 	er in U.S.			? (Specify Yes or No- uerto Rican, etc.)	- 14. Race Black	e - American Indian, k, White, etc.
al ylalida 2.12.13-0030	De lied within 7.2 hours are locally with the waryfail half Hydron. Nat Hydron. No other than "natural", or items 23a or 28a-1 chow event, the Medical Exampler must be notified at	by	3 □ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 Ø N			Specify:	vviile
5 5	n "natu	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	completed)	(Gi	cedent's Usual Occi ve kind of work don b. DO NOT use retir	e during most of	working	16b. Kind of Bu	siness/Industry School System
7	ygiena yerthe	Com	12	College (1-4or 5+)			Bus Aide			<u>, </u>
ב ב	A should be lifed within and Mental Hygiena. Is marked other then eumatic event, Its Mi	To Be	17. Father's Name (First, Middle, Last) Willard Clayto	on Davidson			18. Mother's	Name (First, Middle, Be	etty Ann Mis	
a	and M s mar umat	_	19a. Informant's Name/Relationship (Type		19b. Ma	iling Address (Stree	et and Number o	r Rural Route Numbe		
	eaith a m 27 is		Mr. Steven Coleman	Son			Way Elkrid	ge, Maryland 2		
2	permit. Fages i end z should Department of Health and bell Importent: if Item 27 is marke any Injury or other treumatic <u>once.</u>		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)		cemetery, c	position (Name of rematory or other p		Date 09/14/2006		City or Town, State
	Departme Importen any Injur		21. Signature of Funeral Senice Licensee	D "	Hopkins Me	ethodist Churc 22. Name and Add	ress or Facility		1 1191	nana, waryana
ם :	80 5 5 8		U MULOULISON	thuch	M01293	3871	Funeral Ho	bia Pike Ellico	tt City, MD 2	21043 Approximate
P	hysician		23a. Part 1. Enter the disease, or complicion shock, or heart failure. List only one Immediate Cause (Final disease or condition	cause on each line.	o douth. Do not	smar the mode or a	, mg, 30011 03 501	alao or respiratory ar	7000,	Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a c	onsequence of):		1 1/			7
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a c	onsequence of):	Melose	phritis	9		8 years -
	icien and	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last	Due to (or as a c	onsequence of).					`
	nysicien and 6	calE	d.							
	ing phy e as th		IF FEMALE:							
	a attend	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No	 c. If yes, outcome of a superior of the superior of	Fetal death	3 □Ectopic pregnar 5 □ Other (specify)			23d. Date Mor	e of delivery nth Day Year
	d by the	Phys	9 Unknown	9□ Unknown				00 - 0:44		ibuta ta di ancida
Solds,	icien: The law requires man the death certifica certificate has been signed by the attending ph rector, page 2 should be detached for use as th	þ	Part II. Other significant conditions cont	he estuple	MLT dy	shotes Ch	LATALE .			ibute to the cause of death? 3 Probably 4 Unknown
2	as beer 2 shou	Completed	distructive wimon	my doord	er, 45	hera -		24a. Was	osv p	Were autopsy findings available prior to completion of cause of
ב ק	n: Ine ficate h r, page					`		1 ☐ Yes	№ No 1	death? □ Yes 2X No
5	s certi	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital:	2 ER/Outpa	tient 3 DOA	Whos	Death (Check only only only only only only only only		er (Specify)
5 2	ing rnys		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Y	28b. Time	e of 28c. In	ury at ork?		now injury occurr	
	r death octor: /	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury	- At home, farm,		□Yes 2□No e			er or Rural Route Number,
5	urs efte		4 Homicide	building, etc. (City or Tox		
:	To the hours effer death. The within 24 hours effer death. Within 24 hours effer death. To the Funeral Director: Affer this certificate he completely filled in by the funeral director, page	edicai	29a. Certifier Certifying Physi (Check only 2 Medical Examination)	er: On the best of receiver: On the basis of example states	kamination and/o	eath occurred at the r investigation, in my	time, date and p opinion, death of	lace, and due to the occurred at the time,	cause(s) and ma date and place, a	nner as stated. and due to the cause(s)
	withir To th	W	29b. Signature and title of certifier			29c. Lice	nse number		29d. Date signed	(Month, Day, Year)
	, ſ		30. Name and address of person who con	npleted cause of dea	th (Item 23a) (Tvi	De. Print)	1523		7/10/	0.6
	H		237 W. LANVA	ILE STAKE	T , BAU		MD Z	1217		
	Sta Registi		31. Date filed (Month, Day, Year) CFD 1 3 20	32. Registrar's	s Signature	Coaste?				

06-06144 David L. Earwicker

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		- For State egistrar		Cer	tificate o	f Death				Reg.	No.	200	c 2001
Physicia		I. Decedent's Name (First, Middle	e,Last)							Date of Death Month	ay Y	Z U U	3 ime of peath
ledical Examir		David L. Earv								Month E Lugust 17, 2			2020 hrs
	4	4a. Facility Name (if not institution		umber)		4b. City, Tow Baltimo		cation of [Death		4c. Count	y of Death	
		500 Block South Vince		17 4 11 11	4 4: (mallo mi m. s)	If Under 1		If Under 2	24Hrs 18	Date of Birth/	MM/DD/YY	VVV Q Birth	place (State or
Funeral	1	5. Social Security Number	6. Sex	7. Age (In yrs. I		Months	Days	Hours		Nov 3,		Enroise	
Director	L	219-82-8254	1 X M 2 F	30	-Yn	S.				100 3,			may)2102 y 20110
> 2		Usual Residence of Decedent 10a. State 10b. County		I10c. City	Town or Loca	tion							10d. Inside City Limits
w any	- 1	MD Tool dealing		,	Baltim								1 X Yes 2 No
Aaryland 28a-f show 1 at once.	휘	10e. Street and Number			Dartin	10f. Zip Co	ode			10g	. Citizen of	What Count	try?
or 28s	Director		- 1					1220				TICA	
ith the 23a c		3102 Georgetov		ecedent Ever in U	S 13 W	as Decedent		1230 anic Origin	n? (Speci	fy Yes or No-	14. Ra	USA ace - Americ	can Indian, Black,
ath w	uneral	1 X Never Married 2 M	arried Armed	Forces?		Yes, specify (W	hite, etc.	
er de	<u>.</u>	3 Widowed 4 Div	1 X Yes	2 No	1	Yes 2 X	No	specify:			Specif	y: wh	ite
irs afi tural'	b b	15. Decedent's Education (Spe	or Dates:			nt's Usual O					6b. Kind of	Business/In	ndustry
72 hou	Completed	Elementary/Secondary (0-12)	College	(1-4 or 5+)	during r	most of working	ig lite. L	JO NOT u	se retired)			
thin 1	림	12	0		car	techn						otive	
5-0 ed wi	ड	17. Father's Name (First, Middle	, Last)				18			irst, Middle, Ma		me)	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	Be	Donald Dean		r			丄			ee Kirb		01-11-	7: 0-4/
Should be filed with and Mental Hygiene 77 is marked other that	유	19a. Informant's Name/Relations								al Route Numb		2122	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-fish or other traumatic event, the Medical Examiner must be notified at once		Donna Earwi	cker/sist		Place of Dispo					1timore		on - City or	
S I E E		1 Burial 2 Cremation	n 3 Removal		crematory or o								
iment ment tant:	1	4 Donation 5 X Other S	pecify: in s	ate _	Loo	Name and A	dessa	of Equility					_
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other ti	1	21. Signature of Funeral or price	Sicensie 1	Directo:						655 W.	Balti	.more	Street
	4	23a. art I. Enter the di lease	complications that	caused the deat	n. Do not enter	altimo	re, dying, s	uch as ca	rdiac or re	spiratory arres	st, shock, or	heart	Approximate Interval
Physician /Medical	- 1	failure. List only one cause	e on each line.										Between Onset and Death
Examiner	- 1	Immediate Cause (Final disease or condition resulting in death)		a consequence	of):								
		Sequentially list conditions,	b										
	ner	if any, leading to immediate cause. Enter Underlying Cause		s a consequence	of):								
	Examiner	(Disease or injury that initiated events resulting in death) Last	C	s a consequence	of):								
recuted 1 and - transit			d										
ial ia	Medical	UNPENDED	AMENDE	D									
760, icate be exe	Me	IF FEMALE.		s, outcome of pre				7	-			e of delivery	
687 certific iding se as t	sician	23b. Was decedent pregnant in past 12 months?		e birth gnant at time of c		Fetal death		Ectopic	pregnanc	Э	Mont	n L	Day Year
Box 687 e death certific the attending performs as the	/sic	1 Yes 2 No 9 Ur	lun aven	known	5(Other (Speci	y)						
D. E r the d by the ached	Phy	Part II. Other significant cond	itions contributing	g to death but not	resulting in the	e underlying o	ause gi	iven in Par	rt I.	23e. Did tot	acco use c	ontribute to	the cause of death?
, P.(ires tha signed be det	l by									1 Yes	2 No	3 Prot	pably 4 🗸 Unknown
ords, w requir s been s should	etec		,							24a. Was a autops			topsy findings available completion of cause of
COI e law e has l	Completed									perform	ned?	death? 1 ✔ Ye	
tal Recinn: The certificate		25. Was case referred to medic	al			26	.Place	of Death (Check on				
/ital Rec ysician: The his certificate director, page) Be	examiner?	Hospital: 1	Inpatient 2	ER/Outpatie	ent 3 DO	A C	Other ₄	Nursing	Home 5 F	Residence	6 🗸 Othe	r: Scene
Division of Vital Records, P.O. tal or Attending Physician: The law requires that it are death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact	1:	27. Manner of Death	28a. D	ate of Injury	28b. Time o	of Injury 2	c. Injur	y at Work		8d. Describe h nknown	ow injury oc	curred	
On endin ath. or: A	ţi		Turing A.v.	onth, Day,Year) ND: 17, 2006	FOUND: 2007 hrs		1Y	'es 2 🗸	No O	HKHOWH			
ivisior or Attencafter death Director:	lica	2 Accident Inv	280 5	lace of Injury - At		reet, factory,	office bu	uilding, etc	c. 2	8f. Location (S or Town, St		umber or Ru	ural Route Number, City
Div oital o ours af eral D	Certification:			ify) Woods					50	00 Block S	outh Vinc	ent Stre	et, Baltimore, MD
Division of Vital Records, P.O. Box 68. To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as t	<u>8</u>	29a. Certifier 1 Certifying	Physician: To the	best of my knowle	edge, death oc	curred at the	ime, da	ite and pla	ice, and d	ue to the cause	e(s) and ma	nner as star	rted.
Fo the vithin complex	Medical		aminer:On the bas	sis of examination er stated.	and/or investi					ine time, date a			
_	Ž	29b. Signature and title of certif	her 11	0 n	() A 1	290.	O.C.N	e number				18, 2006	onth, Day, Year)
		(aro	TH	al	LUI	1	U.U.I	VI.L.			rayust	10, 2000	
		30. Name and address of person				n Street, E	altim	ore MD	21201				
			ssistant Medic	Registrar's Signa		, Jueet, E	- Control		_ 1201				
S Regis	tate strar	(1) 1 2	2006	Column Signa	or Apr	occi							

	-	For State Registrer		State o	f Maryla	and / Depa <i>Cei</i>	artment of F rtificate of I	lealth and N <i>Death</i>		giene 2 Reg. No.	006	29012
		Decedent's Name	(First, Middle,	Last)					2. Date of De	ath	Year	3. Time of Death
Physicia /Medica		Marty			A.		Edmonds	5	Septem	ber 8,		18:05 ₽ ^M
Examine		4a. Facility Name (If	not institution,	give street and nur	mber)		4b. City, Town, o	r Location of Death		4c. Co	unty of Death	
		274 Colga						ndalk	1		Balti	
Funeral		5. Social Security No		6. Sex 1 X M 2□ F	7. Age (In yi	rs. last birthday) 40 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bir (Month, Da May 7,	1966	9. Birthr Coul	place (State or Foreign htry) land
Director	-	213-06-23 Usual Residence of				40			11627 . 7			
nylan show		10a. State	10b. County		10c.	City, Town or Lo					1	1 ☐ Yes 2 ☐ VNo
he Ma	ecto	Maryland	Balti	more		L	undalk			10a Citizen	of What Cou	
a or 2	ב	10e. Street and Num 274 Colga		nuo			10f. Zip Code 21 22	22			USA	nuy:
ms 23	Funeral Director	11. Marital Status	ice Ave.	12. Was Dec	edent Ever in	1 U.S. 13.		lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No		Race - Americ	
be filed within 72 hours after death with the Maryland lat Hygiene. Id other than "natural", or Items 23a or 28a-f ehow event, Ite Mudical Examinat must be notified at	þ	1 Never Marrie 3 □ Widowed		Armed Formed 1 Test of Pear or D	2 X No ve X No		1 ☐ Yes 21 No	Specify:	o riican, etc.)	1	^{Black,} White, ecify: Whi	
72 ho 'natur	Completed	(Speci	15. Decedent	s Education t grade completed)		16a. Dece (Give	dent's Usual Occup	oation during most of world)	king	16b. Kind	of Business/In	dustry
within one. than	mp	Elementary/Secon	ndary (0-12)	College (1-4or 5+)					w 14		w1=0
filed Hygie ther ther ther	ပိ	12 years 17. Father's Name (First, Middle, L	_ast)		NEV	ER WOLL	18. Mother's Nam	ne (First, Middle		K WOL mame)	ωv ,
ld be lental ked o	To Be	Roy Edmor	nds					Barbar	a Shifl	ett		
shou and M mar		19a. Informant's Na	me/Relationsh	nip (Type, Print)		,	•	and Number or Ru				Code)
and 2 ealth m 27 I		Roy Edmor		fat	her			Avenue, D			ion - City or To	- Ctata
permit. Pages I and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "natural", or Items 23a or 28a-f show ery injury or other traumatic event, its Mudical Examinar must be notified at once.		20a. Method of Disp 1 ☐ Burial 2] 4 ☐ Donation	Cremation	3 □Removal from pecify)		ayview C	osition (Name of matory or other plan rematory	11,	ember 2006	Balti	more C	ity, MD.
permit. Departi		21. Signature of Fu	horus Service L	Licensee Con	nel	la ?	2. Name and Addre Connelly 1 110 Soll	ess of Facility Funeral H ers Point	lome Of Road,	Dundal Dundal	k,P.A.	21222
		23a. Part1. Enter the shock, or hear	ne disease or nt failure. Ilist								•	Approximate Interval Between Onset and Death
Physician		Immediate Cause (disease or condition resulting in death)	Final n	_a Self	infict	red Gw	nshotu	round t	o hea	<u>d</u>		5 minutes
/Medical Examiner		resulting in dealin)			(or as a cons							
	ē	Sequentially list con if any, leading to im	nditions, imediate	b. Due to	(or as a cons	sequence of):						
outed ansit	Examiner	Sequentially list cor if any, leading to im cause. Enter Unde Cause (Disease or that initiated events	rlying injury	c								
cate be executed physician and the burial-transit		resulting in death) L	_ast	Due to	(or as a cons	sequence of):						
ate be	dicai			d								
		IF FEMALE:		23c. If yes, ou	tcome of pre-	anancy		7777		224	. Date of deliv	
wrequires that the death certificate of the strength of the second of the strength of the stre	Physician/Me	in the past 12	months?	1 Live	birth 2 ☐ F	etal death 3	□Ectopic pregnanc □ Other (specify) _	у		230	Month	Day Year
t the d by the ached	hysi	9 ☐ Unknown		9□ Unkn	own							
s tha	by P	Part II. Other signif	icant condition	ns contributing to c	leath but not	resulting in the u	inderlying cause gr	ven in Part I.	i			the cause of death?
equire sen si									10	Yes 2∐N	lo 3∐Pro	bably 4 Unknown
has has	completed		.						24a. Was auto perf 1 ☐ Yes	s an 2 opsy ormed? 2 X No	!4b. Were auto prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of
ysiclan: The is certificate director, pag	BeC	25. Was case refer examiner?	red to medical	Daniel L			Vou	26. Place of Dea	ath (Check only	one/		
	2	1X Yes 2 ☐ 27. Manner of Death		Hospital: 1 28a. Date		2 ☐ ER/Outpatie	nt 3LJ DOA		lome Res 28d. Describe		Other (Speci courred	fy)
Attending Physiclan: r death, ector: After this certific by the funeral director.	ertification;	1 Natural	5 Pendin investig	g (Mor	ith, Day Year		Wo	rk?]Yes 2. Man		licted	Gun	shot
Atten r deat ctor: by the	flca	2 ☐ Accident 3 ☐ Suicide	6 Could r	not be 28 Place	e of Injury - A	At home, farm, st	reet, factory, office		28f. Location	(Street and N	2 d d lumber or Rur	al Route Number,
s afte s afte et Dire	Cert	4 Homicide		build	ling, etc. (Sp.	ome			324 C	State)	D ZI	222
To the Hospital or Attending Physwithin 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di	edical (29a. Certifier (Check only one)	1 Certifyin	g Physicien: To th Exeminer: On the b and mar	e best of my pasis of examiner stated.	knowledge, dea nination and/or in	th occurred at the ti nvestigation, in my	me, date and place opinion, death occu	e, and due to the arred at the time	cause s) an , date and pla	d manner as ace, and due	stated. to the cause(s)
To the Mithin To the	Me	29b. Signature and	title of sertifier				29c. Licen:	se number		29d. Date s	igned (Month	Day, Year)
		Th	3 harry	MD	Depr	yte	1)18	3667		Septo	mber	9,2006
6		30. Name and addr	ess of person	who completed cau	se of death (Item 23a) (Type	Print) 2 H:(C7	: Luther	ville,	Md 2	109	P,2006
Sta Registr		31. Date filed (Mo	th, Day, Year) 1 3 20	06 /32.1	Registrar's S	ionature	2.1		I			
51311		3Et	TOFO	1000		A. C.						

		1 - For State Registrar	State of M	Maryland .	/ Depa	artment tificate	of H	ealth and Death	Mental H	ygiene Reg. No	2006	29013
Phy	sician	Decedent's Name (First, Middle, La		TOGEN	T 3	FRE	VMZI	AT.	2. Date of I Month	Death Da	y Year	3. Time of Death
/M	edical	4a. Facility Name (If not institution, give		/IRGIN	IA			Location of De	SEPT ath	. 12 4c	, 2006 County of Deat	6:55 A M
Exa	miner	CARROLL LUTHER						INSTE			CARROL	
Fune	ral	Social Security Number 6.5	Sex 7. /	Age (In yrs. last		If Under Months		If Under 24 H Hours Mi	rs. 8. Date of B	lirth Day, Year)		nplace (State or Foreign untry)
Direc	tor	212-68-8243 Usual Residence of Decedent	W 201	90	Yrs.				6/15	/191	6 MAR	YLAND
land ow		10a. State 10b. County		10c. City, T	own or Lo	cation						10d. Inside City Limits
Mary 9-1 sh	ģ	MD CARROI	L	WES	IIMT	STEF	}					1 ☐ Yes 2X No
th the	Jrec	10e. Street and Number				10f. Zip	Code			10g. Ci	tizen of What Co	untry?
ath wi	rai	709 HOOK RD.	,					157			JSA	
ore, Maryland 21215-0036 s. 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 271s marked other than 'natural', or items 23s or 28s-1 show maryland in the trainmails and	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ◯ Widowed 4 □ Divorced	12. Was Deceder Armed Force 1 Tyes 22 If Yes, Give Year or Dates	s? No		Was Deced f Yes, spec 1 ☐ Yes 2			(Specify Yes or I erto Rican, etc.)	No-	14. Race - Ame Black, White Specify: WHI	e, etc.
Phour atturn	led		ducation		6a. Dece	dent's Usua	l Occupa	tion		16b. K	(ind of Business/l	
215	Completed	(Specify only highest gri	ade completed) College (1-4c	or 5+)	(Give	kind of wor DO NOT us	k done d e retired)	uring most of w	vorking			,
21215-0036 ad within 72 hours aff giene. er than "naturai", or	E OC	10				НО	USE	WIFE		НО	ME MAK	ER
Maryland 2121: dd 2 should be filed within " th and Mental Hygiene. the sign marked other than"	Be	17. Father's Name (First, Middle, Last							ame (First, Midd		Sumame)	
Van Men	2		IAM EZRA				-		MAY GL			
Mar d2 st th and 7 is n		19a. Informant's Name/Relationship (TMINST:		or Town, State, Z	îp Code) 1 5 7
1 and 2 Health lem 27		20a. Method of Disposition	TA - 1	20b. Place	e of Dispo	sition (Nam	e of	1	Date		ocation - City or	
Peges nent of 1	5	1 ☑ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specia		ceme	etery, crer	natory or ot	her place	ery 9/1	15/06		LLWOOD	
Baltimore, N permit. Peges 1 and Depertment of Health importent: if Item 27	DUCE.	21. gnature of numeral Service Lice		F	22	. Name and	Addres	s of Facility F	LETCHE	R FU	NERAL H	HOME
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caus	ed the death. D							STER,	Approximate Interval Between
(SACO) (Medic Examination of the purish land the burial land the burial land	al Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Olisease or injury that initiated events resulting in death) Last	b. Due to (or a	as a consequent	~ ce oi).	10 t	× 1	that-	skrili			
1.0. Box 6 t the death certifi by the ettending	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		2 Fetal death	ath 3	Ectopic pre					23d. Date of deli Month	very Day Year
rds, P. quires that in signed b	ē A	Part II. Dther significant conditions of	contributing to death	but not resulting	ig in the u	nderlying ca	use give	n in Part I.				the cause of death? bably 4 □Unknown
Vital Records, stelen: The law requires t certificate has been signe	ι Ω,	CKD							24a. Wa aut per 1 🗆 Yes	opsy formed?	prior to c death?	opsy findings available ompletion of cause of
Vital F vicien: Th certificete	Be	25. Was case referred to medical examiner?						26. Place of D	eath (Check only			
of Vita Physicien: r this certific	12	1 ☐ Yes → No		tient 2 ER/				4 Nursing	77		6 □Other (Spec	ify)
	ō	27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio		jury 28 Day Year)	b. Time of Injury	28 M	Bc. Injury Work 1 Y	at ? es 2 ∐ No	28d. Describe	how inju	ry occurred	
DIVISION Attentors after death rei Director:	Certifi	3 Suicide 6 Could not b	building,	njury - At home etc. <i>(Specify)</i>					City or T	òwn, State	9)	ral Route Number,
Division To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After	Medical	29a. Certifier (Check only one) Lack Certifying Phase Ce	nysicien: To the besing and manner	of examination	dge, death and/or inv	occurred a restigation,	t the time in my op	e, date and pla inion, death oc	ce, and due to th curred at the time	e cause(s e, date and) and manner as d place, and due	stated. to the cause(s)
To the To the	Ž	29b. Signature and title of certifier	es cer)		29c.	License	number 5170	5	29d. Da	te signed (Month	2006
6		30. Name and address of person who	completed cause of	death (Item 23	a) (Type,	m D	R,	Hes	tmin	stes	c, MD	2006
Red	State istrar	31. Date filed (Month, Day, Year)	RH .	strar's Signature		40						

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2006 29014 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month Day Oa 9:25 AM Greene Intoinette 06 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Reisterstown (Chereywood) Paltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 🗷 F 218-44-7442 Director 10/25/1947 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a State item 27 is marked other then "natural", or Itema 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2 🗷 No Funeral Director Baltimore atonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 807 pouthridge 51338 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 😿 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tyes 2 No. Specify: Black þ Specify 3 SWidowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) year Officer Department of Corrections orrectional permit. Pages 1 and 2 should be file Deportment of Health and Mental Hy Important: If Item 27 le marked ofth eny injury or other traumatic event page. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence 2 Lammon IRENE GISSEN Tanner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) anstance Greene (day hter) 807 Southfidge Rd, Cotonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗷 Burial 2 □ Cremation 3 □ Removal from State King Park 4 ☐ Donation 5 ☐ Other (Specify) 09/13/2006 Randallstown, MD 22. Name and Address of Facility
Voughn C. Greene Funetal SYC
19151 Balto Not Pine, Baltimore MD 21. Signature of Funeral Service Licensee (greene 21229 23a. Part1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear tailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Metastatic adenocarcinoma of unknown /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of) attending physicien a for use as the buriat-Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE . If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been sig 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 3 No To the Hospitel or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 10 1 Inpatient 2 ER/Outpatient 3 DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier cal 2 ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Karen R. Balett, M.D. DOO58676 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25 Main steet, suite 200, Reisterstown MD 21136 Karen L. Babitt, 1.1). 31. Date filed (Menth, Day, Year) 32 Registrar's Signature State Registrar 2006

		·	Registrar	State of Marylar	id / Depa <i>Cei</i>	artment of F tificate of	lealth and <i>Death</i>		Reg. No.	006	29016
П	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	Day	Year	3. Time of Death
	/Medic	al	Dorothy Victoria G. 4a. Facility Name (If not institution, give st.			4h City Town o	or Location of Dea	\$EPTEM!	-	3. 2006 ounty of Death	1:38 A ^M
	Examin	er	Saint Joseph M	edical Cen	ter	40. Oky, Town, C	Tow		40. 00		imore
	Funeral Director		5. Social Security Number 6. Sex 217-14-9106	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		n Year) 1920	9. Birthp Cour Mary	elace (State or Foreign http) Land
	and * *		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				1	0d. Inside City Limits
	Maryli f eho	JO.	Maryland Baltimor		rkvill						1 ☐ Yes 2XXNo
	r 28a-	rect	10e. Street and Number	- Tu	ueviii	10f. Zip Code	 		10g. Citizer	n of What Cour d State	ntry?
	th with	alD	9211 Smith Avenue			21234			of Am		S
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if item 27 is marked othar than "natural", or items 23a or 28e-f show amy injury or othar traumatic event, the Medical Exactional be inclified at 2006.	Completed by Funeral Director	11. Maritaf Status 12 1 Never Married 2 Married 3 Married 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates:	-	Was Decedent of F f Yes, specify Cub	dispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No arto Rican, etc.)	14.	Race - Amend Black, White, Decify:	etc.
Ö	2 hou	ted	15. Decedent's Educa		16a. Dece	dent's Usual Occup	pation	orkina	16b. Kind	of Business/Inc	
215	ithin 7 ie. ien "n	nple	(Specify only highest grade Elementary/Secondary (0-12)	Coflege (1-4or 5+)		kind of work done DO NOT use retire		orking			
7	tygien har th	Cor	12 th 17. Father's Name (First, Middle, Last)		So	lesperso	T	ame (First, Middle,		thing	
anc	ntal H	Be	William Mohr					et Sisson		mamey	
7	should nd Me mark imatic	ဥ	19a. Informant's Name/Relationship (Type	ə, Print)	19b. Mailir	ng Address (Street		Rural Route Number		own, State, Zip	Code)
Š	elth al 27 le		David Grammer (Son	James - 11940 - 11941 - 11941	41 Pe	rry alls	Place;	Notting	ham, N	larylan	d 21236
ore,	of He of Item		20a. Method of Disposition 1 ☐ Burial 2 XX remation 3 ☐ Re		Place of Dispo cemetery, crer	sition (Name of natory or other pla	ce) Se	p. Date,	20c. Local	tion - City or To	own, State
Ë	Pag ment ant: it ury o		4 □Donation 5 □ Other (Specify)	Bay	rview C	rematory	The	2006	Balti	nore, M	aryland
Baltimore, Maryland 21215-0036	permit. Depart import any inj		21. Signature of Funeral Service Licenses	Rinak	22	. Name and Addre	ess of Facility SC 97 Bo	himunek 105 Belai Utimore,	r Road Mary	le Home Land 21	, Inc. 236
			23a. Part1. Enter the disease, or compfic shock, or heart failure. List only one	ations that caused the deat cause on each line.	th. Do not ent	er the mode of dyi	ng, such as cardi	ac or respiratory a	rrest,		Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as a consec MYOCARDIA		~ n ~ T T ~ N I					
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•			IF FEMALE:								
P.O. Box	es that the death certifigned by the ettending be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregn. 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a 9 ☐ Unknown	af death 3	Ectopic pregnanc Other (specify)	у		230	d. Date of delive Month	ery Day Year
	law requires that es been signed b 2 should be deta	by Pl	Part If. Other significant conditions cont	ributing to death but not res	sulting in the u	nderlying cause gr	ven in Part I.	23e. Did t	obacco use	contribute to the	he cause of death?
ğ	w require been sig should b		,					10,	Yes 2□!	No 3∏Prob	pabfy 4 Unknown
il Records,	The ate h page	Completed						24a Was autop perfo 1 ☐ Yes		prior to condeath?	psy findings available mpletion of cause of 2021No
Vita	Physician: The raths certificate ral director, pag	Be	25. Was case referred to medicaf examiner?	spitaf:		0#	her	eath (Check only o			
ō	Phys r this ral dii	.T	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of fnjury	28b. Time o	IT 3LI DUA	4 🔲 Nursing	Home 5 Resident			(y)
lon	Attending or death. actor: After by the fune	ıtlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Wo	rk?]Yes 2∐No				
Division of Vital	i or Attendater death Director:	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci		eet, factory, office		28f. Location (. City or To	Street and N vn, State)	lumber or Rura	al Route Number,
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examin	cian: To the best of my known: On the basis of examination and manner stated.	owledge, deat ation and/or in	n occurred at the ti vestigation, in my	ime, date and pla opinion, death oc	ce, and due to the curred at the time,	cause(s) ar date and pl	id manner as s ace, and due to	tated. o the cause(s)
	To the within To the	Me	29b. Signature and time of certifier			29c. Licen:	se number		29d. Date s	signed (Month,	Day, Year)
	/		> / /h			D 4	6356		Sep7	em her	8,2006
	12		30. Name and address of person who con	npleted cause of death (fter	m 23a) (Type,	Print)		(6	11		0/200
-			KHOSROW TABASSI			R DRIVE	TOWSON	MARYLA	S QVE	1204	
	Sta , Regist		31. Date filed (Month, Day, Year)	32 degistrar's Sign	ature A	erle					

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registra Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) SEPTEMBER CALVIN 9 2006 **Physician** GRUBE 0700 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Randallstown Baltimore Northwest Hospital If Under 1 Year | If Under 24 Hrs. 6. Sex 1 **2** M 2 ☐ F 8. Date of Birth 02/04/1925 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 81 218-18-7419 Vrs Maryland Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow traumatic event, the Medical Examiner must be notified at Catonsville Maryland Baltimore 1 ☐ Yes 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 end 2 should be filed within 72 hours after death with t. Department of Heelin and Mental Hygiene. Important: If Item 27 is marked other than "natural" eny injury or other traumatic average. 21228 United States 1224 N. Rolling Road 12. Was Decedent Ever in U.S. Armed Forces? 1 전Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🖾 No Specity: 2 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Contractor Home Improvement 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carrie Harrison Grube ٩ 19a. Informant's Name/Relationship (Type, Print) Steven J. Garrison / Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1526 Kirkwood Road, Baltimore, Maryland 21207 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State New Cathedral Cemet. 09/13/2006 Baltimore, Maryland 4 Denation 5 Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21 Signature I Funeral Service Licenses 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) sete has been signed by the attending physician page 2 should be detached for use as the buria Division of Vital Records, P.O. Box 68760 Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Day Year Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient Certification: To **ER/Outpatient** 3 DOA this 28a. Date of Injury (Month, Day Year) 28c, Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending 1 Natural Injury efter death.

| Director: Aft d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours e To the Funeral L Hospitel 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifie 47 30. Name and address of person who completed cause of death (Item 239) (Type, Print) Randellstrum MD 21133 OLD CLICI 5401 31. Date filed (Month, Day, Year) SEP 1 3 200 32. Registrar's Signature State 1 3 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 2006 29018 For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 3:00 A M Green 11,2006 Rosemary September /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Dundalk 2422 Plainfield Road 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 22, 1939 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🂢 F Maryland Director 219-26-5657 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "neturel", or iteme 23a or 28a-f show event, the Medical Examiner must be nutified at 1 ☐ Yes 2X No Dundalk Directo MAryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 2422 Plainfield Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after c Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "neturel", or Item any Injury or other traumatic event, the Medical Examinar 1 DYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Motor Freight Payroll Clerk 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lucille Mc Daniel George W. Lowery 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2422 Plainfield Road, Dundalk, MD. 21222 Joseph B. Green Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) September 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery Dundalk, MD. 14, 2006 ²² Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. Listonly one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, tmmediate Cause (Final disease or condition resulting in death) **Physician** Metastano Malignant month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 N Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 XNo 1 Yes 1 Yes funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending after death.
I Director: All
d in by the fur 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide Hospital
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 Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Exeminar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai completaly within 2 29b. Signal fe and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DA5530 9-11-06 e Philadelphia road, MD 2123 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0S. SIVASAILAM SUITE 200 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 1 3 2006

Registrar

					artment of Health and Natificate of Death	-	jiene eg. No. 2 (006	2901 3. Time of Death
Physici /Medio		BARBARA E	GARBET			Month	2 Day	06	10:30
Examir	ner	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Location of Death			ty of Death	
 		10902 Hillcrest Drive 5. Social Security Number 6. Security Number	7. Age (In yrs. last	birthday)	Laure1 If Under 1 Year If Under 24 Hrs.	8. Date of Birth		loward 9. Birthpl	lace (State or Foreign
Funeral Director			IM 201 61	Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day Jan. 14,	, Year) 1945	Mi chi	lace (State or Foreig try) gan
f show	lor	10a. State 10b. County Maryland Howard	10c. City, To		ocation			10	0d. Inside City Limits
7.28s	Director	10e. Street and Number	Lou		10f. Zip Code		l0g. Citizen of	What Coun	try?
23a o	a D	10902 Hillcrest Drive			20723		United S	tates A	America
be lied within /2 hours after death with the Maryland ital Hygiene. Ital Hygiene. d other then "naturel", or items 23a or 28a-f show event, it a Medical Examinar must be notified at	by Funeral		12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ [ऒ No If Yes, Give Year or Dates:	ĺ	Was Decedent of Hispanic Origin? (Sr If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No- pecify Yes or No-	81	ace - Americ ack, White, e ify: White	etc.
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d 2 should the and Ment of the marked traumatic of the marked traumatic of the should be should	2	19e Informant's Name/Relationship (Ty Angela Louise Fie	ming/daughter		ng Address (Street and Number or Ru	ral Route Numbe		n, State, Zip	Code)
Heal Heal em 2		Ange to Penns 11/Daughts 20a. Method of Disposition	20b. Place	of Dispo	osition (Name of	rel, MD 20'	723 20c. Location	- City or To	wn, Slate
20 2 2		1 ☐ Burial 2 💆 Cremation 3 ☐ F	emoval from State	etery, crei	matory or other place)	11. 2005			
E 40 -3		4 □ Donation 5 □ Other (Specify) 21. Signature of Huneral Service License			2. Name and Address of Facility	11. 2006	Cato	nsville	י, ויוט
Deport Import any of	i	1 han 8	Will.		leck Funeral Home 7601	Sandy Sp	ring Roa	d Laure	1 MD 20707
Physician /Medical Examiner ponual-transit	Examiner	23a. Part1. Erfer the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent Due to (or a) do (or	ce of):	CANCER STONDER CAN			1	Interval Between Onset and Death
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ysician: is certific director,	Be	25. Was case referred to medical examiner?	lospital:	10	Other	th (Check only or			
ding Phys	. To	1 ☐ Yes 2 ☐ KNo 27. Manner of Death	28a. Date of Injury 28	b. Time o	nt 3 DOA 4 Nursing H	ome 5 Resid			γ)
or Atten fter deat Director: in by the	Certification:	1 ∏ Natural 5 ☐ Pending 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	(Month, Day Year) 28e. Place of Injury - At home building, etc. (Specify)	Injury , farm, st	M 1 ☐ Yes 2 ☐ No	28f. Location (S City or Tow		nber or Rura	l Route Number,
To the Hospitel or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of my knowle ner: On the basis of examination and manner stated.	dge, deat and/or in	th occurred at the time, date and place nvestigation, in my opinion, death occu	, and due to the orred at the time, o	ause(s) and n late and place	nanner as st e, and due to	ated. the cause(s)
To the Within To the	Me	29b. Signature and title of certifier Two	WEN MO		29c. License number P Z O 789	2	eg Um	ber 8	Day, Year)
1		30. Name and address of person who co	empleted cause of death (Item 23	05	5 Little PATUXE	W G	lumb	ILM	2
Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	Lack	20				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend item#20a-c,22,perFH,0839,9/27/Certificate of Death
Registrar

State of Manyland / Department of Health and Mental Hygiene 2006
Certificate of Death
Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Lawrence Hancock 30. 2006 6:58 PM August /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4202 58th Avenue #214 **Bladensburg** Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number unk 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F 78 Yrs. May 4, Virginia Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or iteme 23a or 28a-f show the Medical Examinar count ha notified at 1 ☐ Yes 2√ No MDPrince George's **Bladensburg** Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4202 58th Avenue #214 20710 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status fX Yes 2 No If Yes, Give Year or Dates: 1X Never Married 2 Marned Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: black δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) unk 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 DC government ith and Mental Hygir 27 is marked other r treumetic event, unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Anthony Hancock ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Curtis Hoston/cousin 4713 Woodley Avenue Baltimore, MD Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. 4 ☐ Donation 5 ☐ Other Greenmount Cemetery 9/23/2006 Baltimore, MD 22. Name and Address of Faculty Retts Funeral Home 2100 Caroline St. 21. Signature of Funeral Service Licensee Renald S, Wade, Baltimore, MD 23a. Part 1. Enter the disease, or complice shick, or heart failure. List only one plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) ONGERT Physician /Medical Due to (or as a consequence of) Examiner ARPIDMYO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed CORONA Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of defivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No s certificate has b irector, page 2 sl 24a. Was an 1 Yes 2 No Hospital or Attending Physician: After this certification of the tall director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DDA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28c. Injury at Work? Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Naturat 5 Pending To the Hospital or Attending within 24 hours after death.
To the Funeral Director; After completely filled in by the fun. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 14 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CREEN BELT MD 25770 HANOVER 32 Registrar's Signature

State Registrar

31. Date filed (Month, Day, Year)

SFP 1 3 2006

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

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temores

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. PANSURITA, 2111 Humon

2006

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O. O. O.

Physic /Med		1 - State Registrar 1. Decedent's Name (First, Middle, Last) EUA M HA	MCK.		rtificate of Dea	2.	Date of Death Month	Day Year 8 2000	2:20PM
Exam Funera Directo	iner	5. Social Security Number 6. Sex 1 1 1 1 1	reet and number) ILFON T. Age (In yrs. last X 88		If Under 1 Year If Un Months Days Hou	der 24 Hrs. 8.	Date of Birth (Month, Day, Ye Pay 17 191	9. B	ath Truine City inthplace (State or Foreign Country) Limore City, MD
show	j	Usual Residence of Decedent 10a. State 10b. County Megalland Deltimose		Town or Lo				<u></u>	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
n with the M 3e or 28e-f	ai Director	Maryland Baltimore 10e. Street and Number 5703 Kenwood Avenue	Parcin	nore Co	10f. Zip Code 21206		-	Citizen of What (
ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "neturel", or items 23e or 28e-f show or other treumatic event, the Marilial Expris	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1Yes _ 2\overline{\text{D}} No If Yes, Give Year or Dates:	1	Was Decedent of Hispanic If Yes, specify Cuban, Mex 1 ☐ Yes 2 🙀 No Spec		y Yes or No- an, etc.)	Black, Wi	nencan Indian, nite, etc. nite
within 72 hound.	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give	dent's Usual Occupation kind of work done during a DO NOT use retired)	most of working		o. Kind of Busines	
td be filed went Hygie ked other t	To Be Co	17. Father's Name (First, Middle, Last) Henry Michael Jones	IVA	nousew	18. M	other's Name (F	irst, Middle, Mai		g-own thie
C, IVICAL YICA 1 and 2 should I Health and Men 1em 27 is marke	-	19a. Informant's Name/Relationship (Type Chester A Haack		5703	ng Address (Street and Nu B Kenwood Avenus	e Baltim	ore, Maryl	and 21206	
t. Pa rtmen rtent:		20a. Method of Disposition 1	moval from State Cer	metery, cre Air Me	osition (Name of matory or other place) m. Gdns. Septer 2. Name and Address of F			c. Location · City	
Deparition of the policy of th	BAIIN	23a Part 1 Enter the disease, or complic	ations that caused the death.		assahn Funeral 401 Belair Roa	Home Inc	e, Maryla	and 21236	Approximate Interval Between
Pnysiciai /Medica		shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	Due to or as a constitution	ence of):	lee				Onset and Death
ficate be executed the physician and the burial-transit of	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque						years Years
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	2	Part II. Other significant conditions con	ributing to death but not result	Iting in the t	underlying cause given in F	Part I.			to the cause of death? Probably 4 — Unknown
The law require cate has been single.	Completed	De mentia					24a. Was an autopsy performe	d? prior death	autopsy findings available o completion of cause of ? es 2□ No
DIVISION OI VII. MECOLUS, lor Attending Physicien: The law requires that dath. Director: After this certificate has been signe in by the funeral director, page 2 should be 6.	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ E 28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time o Injury	ont 3 DOA Other: 4.0 of 28c. Injury at Work?	286		ce 6 □Other (S injury occurred	pecify)
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To the Hospitel or Ati within 24 hours after of To the Funerel Direct completely filled in by	Medicai C	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examinone)	ician: To the best of my know er: On the basis of examinati and manner stated.	ion and/or i	nvestigation, in my opinion	death occurred	at the time, date	e and place, and o	lue to the cause(s)
To To	2	30. Name and address therson who co wendy Kloese 31. Date filed (Month, Day, Year) SEP 1 3 20	us no	22a\ /Tuno	D3129		250	9/9/0	6
; /		30. Name and address * person who co Wendy Kloese 31. Date filed (Month, Day, Year)	~2 6701 NC	La-le	s St Suite !	4202	Balton	ive de	D 21204

06-06693

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State of Maryland / Department of Health and	l Mental Hygiene

John H. H	ayman		F 01-1-	Stat	e of Maryland					Menta	al Hyg	giene				
		F	- For State Registrar			Cei	rtificate of	Death			1.0	Re . Date of Dear	eg. No. 2	0.6	$\frac{2902}{}$	2
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No.			John H. Ha 4a Facility Name (if not	institution,	give street and numb	er)	4	b. City, To	wn, or L	ocation of		Coptombo	4c. County of	Death		\dashv
		н	Atlantic Genera	I Hospita	al			Berlin					Worceste	er		
	neral		5. Social Security Number			Age (In yrs. I	ast birthday)	If Under		If Under :	24Hrs. Min	8. Date of Bir	th(MM/DD/YYYY)	Foreign		٦
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	any	-	Usual Residence of Deci 10a. State 10b.	edent County		10c. City,	Town or Location	on							10d Inside City Limits	\dashv
P	how a		MD	Harf	ord	Be	l Air								1 Yes 2 X No	
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21215-0036 Juld be filed within 7	Nenta marke even	o Be	John H. Ha	ayman Relationship	(Type, Print)		19b. Mailing	Address	(Street	Marc and Numb	gare er or Ru	t F. E	mge nber, City or Town	State.	Zip Code)	\dashv
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	ician dical		failure. List only or	ne cause or	each line										Between Onset and Death	
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Box 6876 e death certificate	e attending phy		IF FEMALE: 23b, Was decedent pregrast 12 months?	nant in the	23c. If yes, out			tal death	3	Ectopic p	oregnan	су	23d. Date of a Month	Da	y Year	
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Division of Vital Records, P.O. Box 6876	within 24 hours after death To the Funeral Director: completely filled in by the	Medical	[Orloon orly		ner: On the basis of e	examination a										
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N)		30 Name and address of					Conn. Cd	oot D	altimess	NAD	21201		•		
1			Pamela Southa		Assistant Medi	trar's Signat		enn Str	eet, Ba	altimore,	, IVIU Z	1201				\dashv
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ı	Examin	ier	UNIVERSITY OF A	naryland m	EDICA		75R	BA	して」から	RE		NIA	
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	3e or 28e	I Director	10e. Street and Number 4731 Reister	stown Road			10f. Zi	p Code	21215		10g. Citi	zen of What Co USA	
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21215-0036	within 72 ena. then "na he Madic	mpleted	15. Decedent (Specify only highes Elementary/Secondary (0-12) NONE	r's Education st grade completed) College (1-4or :	5+)	(G	. DO NOT i	ork done du	tion uring most of wo	orking	16b. Ki	nd of Business	Andustry
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Maryland		2	19a. Informant's Name/Relations	hin (Turne Print)		10b M	ailing Addres		Stacy J	ackson Rural Route Numi	har City o	r Town State	Zin Code)
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altimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☒ Other (S)		٥	lace of Dis emetery, o	sposition (Na crematory or	me of other place)	Date	20c. Lo	cation - City or	Town, State
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMENID 111-W/1 24a per PHYS . C859 9/13/06 WS
State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Reg. No. 2006 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Coper J. Jackson Month O Year **Physician** ACO (COX 2006 /Medical 4a. Facility Name (Innot institution City, Town, or Location of Death 4c. County of Death Examiner BONSECOURHapi tinor/ Year If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) SEAT 2, **Funeral** Days 24 7830 Hours Months 250 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f ehow 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryla nand Mantal Hygiene.
Then to Health and Mantal Hygiene.
The state of the s 1 es 2 No BALTHORE Director MATHIANO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 313 N. HOURT STREET 21223 USB Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Marned 1 Yes 2 No WWTI Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Be Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Worken 5# grade 17. Father's Name (First, Middle, Last) maintenance 18. Mother's Name (First, Middle, Maiden Sumame BOLL JACKSON EdNA ပ KICHAND 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimone, Md 2/223 313 N. HOURT STREET GEORGIA B. THOMAS 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State permit. Page Department of Important: if any injury or once. rounsville, Mary/mas Cavaralle Uterms Com 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility (HATMAN - HAMI FUN A HOLD 21. Signature of Funeral Service Ucensee 5240 REISTEPHUN LUM Baldmon, Md 212/5 Xru 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Lesmonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1☐Live birth 2 ☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ Hd Division of Vital Records, P.O. 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaccourse contribute to the cause of death? this certificete hes been signinal director, page 2 should be 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Lancatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 THO Medical Certification: To 28a. Date of Injury (Month, Day Year) Director: After the in by the funeral 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation within 24 hours after death.

To the Funerel Director; Af
completely filled in by the fur 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32 Registrar's Signatore State 1 Registrar

			1 - For State Registrar	State of M	larylan	d / Depa	artmen rtificat	t of H	lealth a				2006	29	026
	Physici /Medio		1. Decedent's Name (First, Middle, t Michael Theodore	Kalman							2. Date of Dea Month Septemb	Da	y Year 9, 2006		of Death
}	Examir	ier	4a. Facility Name (If not institution, g Kline Hospice Hor)		, ·	Town, or	Location of Airy	of Death		40	County of Deat		
	Funeral Director		5. Social Security Number 6. 211-28-9897 Usual Residence of Decedent	Sex 7. A 1⊠M 2□F	ge (In yrs. I 68	ast birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	Min.	8. Date of Birt (Month, Day (arch 20	v. Year)	9. Birt Co		e or Foreign ania
	Maryland I-f show	tor	10a. State 10b. County Maryland Freder	ick		r.Town or Lo								10d. Inside	City Limits
	th with the 23e or 28e	ai Director	10e. Street and Number 803 Gabriel Cour	t, Apt. 31	0		10f. Zip	Code					izen of What Co		
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Iteme 23a or 28a-f show any figury or other traumatic event, the Modical Expinition chall be inclified at Apple.	by Funeral	11. Marital Status 123 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces' 1 ☐ Yes 278 If Yes, Give Year or Dates:	?		Was Deced f Yes, spec 1 ☐ Yes		spanic Orion, Mexican Specify:	gin? (Spec n, Puerto F	cify Yes or No- Rican, etc.)		14. Race - Ame Black, White Specify: Whi	e, etc.	
Maryland 21215-0036	within 72 ho ene. then "natur he Medical	Completed	15. Decedent's (Specify only highest g		5+)		dent's Usua kind of wo DO NOT us	rk done d se retired	ation during most)	t of workin	g		ind of Business/		
/land 2	wild be filed Mental Hygi arked other atic event,	To Be Co	17. Father's Name (First, Middle, Las John Kalman	st)		Des	E I gire	L			(First, Middle, obtaina	Maiden		nergy	
, Mar	and 2 sho lealth and m 27 is ma		19a. Informant's Name/Relationship Francis Lison /		1	101 5	tand:	ing I	Rock l	Dr.,	McMurr		PA 1531		
Baltimore,	thent of H tant: If Ite		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	rify)		ace of Dispo emetery, cren thaven	Cre	natoi	су		006	Fred	cation - City or derick,	Máryla	
Bal	permit Deper Impor any in		21. Signature of Funeral Service Lic. 23a. Part 1. Enter the disease, or co			95	01 Ca	atoct	in M	tn. H	lwy. Fr	<u>eder</u>	kot Cod	2170	L
8760,	Physician // Medical Examiner transit sthe purial-transit	edical Examiner	shock, or heart failure. Est onlimmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and the cause of the cause (Disease or injury that nititated events resulting in death) Last	a. Colon C Due to (or as b. Due to (or as c. Due to (or as d.	ancer a consequ	ence of):								Approxim interval B Onset an 2 year	etween d Death
P.O. Box	The law requires that the death certific. Ite hes been signed by the attending pl page 2 should be detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□ Unknown	2 🗌 Fetal	death 3	Ectopic pro						23d. Date of deli Month	/ery Day	Year
ords, P	w requires that been signed b should be deta	by	Part II. Other significant conditions	contributing to death b	out not resu	lting in the ur	nderlying ca	ause give	n in Part I.			bacco u es 2	se contribute to No 3 □ Pro	the cause of	
		Completed								_	24a. Was a autops perform	sy med?	24b. Were autoprior to death?	ompletion of	s available cause of
ž	/sicial	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	n: 2 🗆 🗆	R/Outpatient	200	Othe			Check only or		- Fo:		
ion of	Attending Physician: r death. ector: After this certific: by the funeral director,		27. Manner of Death 1 ⊠Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Inju (Month, Da		28b. Time of Injury		8c. Injury Work	4 🗀 1901	28	e bull Heside		6 없Other (Spec y occurred	W Hosp	olce
<u>N</u>	in the second	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	building, et	c. (Specify))					City or Towi	n, State,			mber,
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	one)	hysician: To the best miner: On the basis o and manner st	t examinati	rledge, death on and/or inv	estigation,	in my op	inion, death	d place, an	nd due to the ca d at the time, d	ause(s) ate <i>a</i> nd	and manner as place, and due	stated. to the cause	(s)
	5 ¥ 5 8		29b. Signature and title of certifier			mi		. License					e signed (Month		
1		-	30. Name and address of person who	completed cause of c	leath (Item	23a) (Type I		D 418	366		S	ept.	. 11, 20	06	
1	v		Kanan H. Hudhud,	M.D. 46_B	Thoma	as Joh	nson	Driv	e, Fr	eder	ick, MI	21	702		
	Sta Registra		31. Date filed (Month, Day, Year) SEP 1 3 21	32 Régistr	ar's Signat	To See	we								

06-06183

Please Type or Print in Black Indelible Ink

State of Marvland / Department of Health and Mental Hygiene Dennis J Killian 2006 29027 1- For State Certificate of Death Reg No. Registrar . Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Medical Examiner 1654 hrs Dennis J. Killian August 18, 2006 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Harford Memorial Hospital Havre de Grace Harford 5. Social Security Number un 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or unk **Funeral** Foreign Country) Days Months Hours Min Director 1 X M 62 2 Nov 23, 1943 Usual Residence of Decedent any 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show MD Cecil Perry Point Yes 2 X No or items 23a or 28a-f shor must be notified at once. death with the Maryland Director 10e. Street and Number 10f. Zip Code Og Citizen of What Country 21901 Perry Point Medical Center USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes 2 X No hours after Divorced Yes, Give Year Widowed 1 Yes 2 X No specify: "natural", Specify. white 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done ${
m unk}$ | 16b. Kind of Business/Industry unk Completed during most of working life. DO NOT use retired) Pages I and 2 should be filed within 72 h nent of Health and Mental Hygiene. ant: If item 27 is marked other than "n Elementary/Secondary (0-12) College (1-4 or 5+) item 27 is marked other than "traumatic event, the Medical Baltimore, MD 21215-0036 unk unk 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk unk Be 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) O.C.M.E. lll Penn Street Baltimore,MD 21201 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, Limportant of injury or other crematory or other place) Burial 2 Cremation 3 Removal from State 5 X Other Specify: in state 21. Signature of Funeral Service Licensee Ronald Salva State Anatomy Board 655 W. Baltimore Street Director MD Part I. Enter the disease, or compl ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line. Between Onset and /Medical Death Drowning Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical X UNPENDED AMENDED attending physician or use as the burial item#23a.27.28a-f.perME.e859.9/15/06 TT Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be IE EEMALE 23c. If yes, outcome of pregn 23d. Date of delivery 23b Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? certificate ✓ Yes 2 1 🗸 Yes 2 [Nο 25. Was case referred to medical 26 Place of Death (Check only one) Be examiner? Other₄ Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 Other: Scene After this 1 🗸 Yes No 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred subject jumped from bridge into Natural 1 Yes 2 No Pending Funeral Director: tely filled in by the f 8/28/2006 4:00 pm 2 water Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 X Suicide Could not be Rt. 40 Bridge oyer or Town, State) determined (Specify) river Susquehanna River, Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical (Check only To the 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) mo O.C.M.E August 19, 2006 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Date filed (Month, Day, Year, State 2006

DHMH 17 Rev 1/2001 OCME 2006

Registrar

	_==		1 - For State Registrar	State of	Marylar	nd / Depa <i>Cei</i>	artment rtificate	of He	ealth a Death	ınd Men	ital Hyg	giene 200	6 29028
I	Physic /Medi		Decedent's Name (First, Middle, L INEZ MARTHA KERI	LEY							Date of Dea Month SEPT.	6 2006	9:25P ^M
	Examir	ner	4a. Facility Name (If not institution, g. 8610 David Avenu	ne			4b. City, To Ba	ltin		County		4c. County of D	nore
	Funeral Director		5. Social Security Number 6. 246 - 12 - 2687 Usual Residence of Decedent	Sex 1 □ M 2 ☑ F	91	last birthday) Yrs.		Days	Hours	Min. DE	Date of Birth Month, Day 2C. 12	, 1914 No	Birthplace (State or Foreign Country) orth Carolina
	e Marylan Se-f ehow	ctor	Maryland Balti	more	10c. Cit	ly, Town or Lo	cation timore	e Co	unty				10d. Inside City Limits 1 ☐ Yes 2 💆 No
	th with th	al Director	10e. Street and Number 8610 David Aver	nue			10f. Zip C	ode 212	234		1	0g. Citizen of What	:Country?
036	72 hours after death with the Maryland natural', or Itema 23a or 28e-f show dital Exaciliar nust be nutlified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Tes 2 If Yes, Give Year or Date	as? ∑X No		Was Decede f Yes, specif 1 ☐ Yes 2		panic Orig , Mexican, Specify:	in? (Specify , Puerto Rica	Yes or No- in, etc.)	Black, W	American Indian, Vhite, etc. White
21215-0036	d within piene. r then	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 12 yrs.	Education rade completed) College (1-4 N/A	or 5+)	(Give	dent's Usual kind of work DO NOT use chen S	done du retired)	ring most		-	16b. Kind of Busine Johns Hop Faculty C	kinsí
Maryland 3	should be filed ind Mental Hygid marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Las William Reed						Par	ilee G	illia		
re, Mar	1 and 2 Health a em 27 le	8	J. Annette Wils 20a. Method of Disposition				David	Ave	nue E		ore,	, City or Town, Stat Md. 21234 20c. Location - City	
Baltimore,	it. Page intment o intent: If injury or		X⊠ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice	rify)		rdens d	of Fai	th C	em. S			Baltimore	
Ä	perm Depa Impo eny i		23a. Part1. Enter the disease, or cor	nplications that cau	sed the deat							imore, Md	. 21236
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	aDue user	eime	uence of):	loens	ı					Interval Between Ones and Death
8760,	death certificate be executed e attending physician and id for use as the burial-transit	Ical Examiner	Sequentially list conditions, I any, leading to himsolate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a conseq	, 							
P.O. Box 6	that the death certific hed by the attending p detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcon 1□Live birth 4□Pregnan 9□ Unknown	n 2 ∏Feta tat time of d	Ideath 3	Ectopic preg Other (spec					23d. Date of Month	delivery Day Year
	w requires that been signed b should be deta	þ	Part II. Other significant conditions Denumber			ultipe in the un		se given	in Part I.		23e. Did tot		e to the cause of death?
	The law ate has b page 2 s	Completed	0								24a. Was a autops perforr 1 ☐ Yes 2	v prior	
	ng Phys ter this neral di	atlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 Ne 27. Manner Death 1 Natural 5 Pending investigation	28a. Date of I (Month,		ER/Outpatien 28b. Time of Injury		Other: Injury a Work?	4 □ Nurs	28d.	5 Peside	e) ince 6 Other (S ow injury occurred	pecify)
Division	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification;	3 Suicide 6 Could not determined	d 286. Place of building,	etc. (Specif	y)			•		City or Towr	, State)	Rural Route Number,
	the Hosp nin 24 hou the Fune npletely fil	Medical	one)	hysician: To the be miner: On the basis and manner	s of examina	wledge, death tion and/or inv	estigation, in	my opir	nion, death	place, and on occurred at	the time, da	ate and place, and o	due to the cause(s)
)	T vo	~	29b. Signature and title of certifier	MD			29c. 1	icense r	22		21	9d. Date signed (Mo) $9/8/0$	onth, Day, Year)
	10		30. Name and address of person who R-Habersat	111 m	t Car	mel K	Print)	Par	ktor	M	Δ'	21120	
¥	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 3	2006 32. Reg	strar's Signa	ture	best			•			

State of Maryland / Department of Health and Mental Hygiene 29029 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 11, **Physician** Christian Charles Lang 2006 3:21 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center Baltimore N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months Days Hours Min. (Month, Day, Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**Ø**M 2□F 59 Feb. 22, 217-46-1534 1947 Maruland Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County filled within 72 hours after death with the Marylan Hyglene. wither then "naturel; or items 23a or 28a-f show not, the Modical Examine must be notified as 1 Yes 2 No Maryland Baltimore Dundalk Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1906 Jackson Road 21222 U.S.A. Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 Xiyes 2 □ No
If yes, Give Victnam
Year or Dates:
Eta 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No altimore, Maryland 21215-0036 Specify White by Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Self-Employed College (1-4or 5+) Elementary/Secondary (0-12) Song Writer Song Writer . Pages 1 and 2 should be filed w iment of Health and Mental Hygler tant: If item 27 le marked other ti jury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jacqueline Elizabeth Pollhamer Christian Lang, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (wife) 1906 Jackson Road, Dundalk, MD 21222 Mrs. Nancy Lang 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Demoval from State permit. Page Department of Important: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. 9/14/2006 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baitimore, MD 21236 21. Signature of Funeral Service Licensee 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Renal Cell Cancer 5 months /Medical Due to (or as a consequence of): Examiner S. pential, list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ending physicien and use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical ettending p IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an certificate has b irector, page 2 sl rmed? 2**⊡** No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director: After this certifica director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ■ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation s after dec. 1 Yes 2 No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Sept. 12, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Myo Thant, 9114 Philadelphia Rd., Suite 208, Baltimore, MD 21237 32. gistrar's Signature 31. Date filed (Month, Day, Year) maske) 2006 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 29030 Certificate of Death 3. Time of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Lest) Month Day Year **Physician** September Sharon Lynn Leight 7:12 Am 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Neme (If not institution, give street end number) Examiner Baltimore St. Agnes Hospital 8. Date of Birth (Month, Day, Year) 9. Birthplace (Sizelle Country)
April 26, 1962 Maryland If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours 1 ☐ M 2 💆 F 218 90 8173 Yrs. 44 Director Usuel Residence of Decedent tha Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County parmit. Pagas 1 and 2 should be filed within 72 hours aftar death with the Marylar Department of Health and Mantal Hygiana. Important: if Item 27 is marked other than "naturel", or items 23a or 28e-1 show with Injury or other traumatic event, the Modical Examinet must be notified at once. 1 ☐ Yes 2K No |Maryland Baltimore **Baltimore** Funeral Director 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21227 U.S. 2933 Louisianna Avenue 14 Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🐼 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☒ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education
(Specify only highest grede completed) Elementery/Şecondary (0-12) 10th College (1-4or 5+) Sales Person Retail Auto Parts 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mildred A. Adcock Herbert G. Whitesell, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3385 Lone Draw Court Powhatan, Virginia 23139 Mildred Whitesell / Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 9/9/06 Bavview Crematory 54☐ Other (Specify) 4 \(\text{Donation} \) Gonce Funeral Service, P.A. 22. Name and Address of Facility an ral Service Licenses 4001 Ritchie Highway Baltimore, Maryland 21225 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ealy one cause on each line. Approximate Interval Between Onset and Death Ent. List **Physician** Immediate Cause (Final disease or condition resulting in death) a Cardiomea /Medical Examiner Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Due to (or as e consequence of) Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

led by the attanding physician and datached for use as the burial-transit Be Completed by

Attending Physician: The law raquiras that the death certificate be axecuted

Aftar this cartificata has baan signed by I funarai diractor, paga 2 should be datach

Division of Vital Records, P.O. Box 68760, after death ō To the Hospital of within 24 hours at To the Funeral D complataly fillad in

Certification: To

Medicai

1 Natural

2 Accident

3 🗌 Suicide

29a. Certifier

4 ☐ Hornicide

31. Date filed (Month, Day, Year)

fillad in by tha funarai

State Registrar

24a. Was an autopsy performed? 1 X Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpetient 3 DOA 27. Manner of Death Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier

1 ☐ Yes 2 ☐ No

Surkmi

28f. Location (Street and Number or Rural Route Number, City or Town, State)

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2□ No

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

Baltimore inn 900 Caton Re 32, Registrer's Signature

2006

5 Pending investigation

6 Could not be determined

State of Maryland / Department of Health and Mental Hygiene 2006 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** SEPTEMBER 8. 2006 John Walter Long 4:40 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2□F Months Days Hours Min. Yrs. July 9 1927 Director 218 28 1233 Pocomoke City, MD Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10a, State permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. important: if item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Medical Examination and Department once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1122 Cowpens Avenue 21286 USA by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: ↓ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3√Widowed 4 □ Divorced WII White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Zurich Co. 12 Claims Attorney 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Walter Hugh Long Rose Gibbons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1122 Compens Avenue Towson, Md., 21286 Deborah A Long Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Manokin Presbyterian Cem. September 14 2006 Princess Am., Maryland 22. Name and Address of Facility
Lassahn Funeral Home Inc 21. Signature of Funeral Servi e Licensee 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final) Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** METASTATIC LUNG CANCER resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed attending physicien and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? Year Month Day 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No be deteched 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 Yes 2 No certificate 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 X Inpatient Certification: To 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funerei Director: After thi
completely filled in by the funeral to 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of dertifier 29c. License number 29d. Date signed (Month, Day, Year) Sertember ogth mella mo 200 6 D 41410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOGINDER P.MEHTA M.D. 7601 OSLER DRIVE TOWSON MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

Ü		1- For State Certificate of D	eath	Reg.	_{No} 200	6 2903
Physicia edical Exami	ın/	Decedent's Name (First, Middle,Last)		Date of Death Month D September 1	av Year	3 Time of Death 0040 hrs
		, ,	City, Town, or Location of De Glen Burnie	eath	4c. County of Death Anne Arundel	
Funeral Director			f Under 1 Year If Under 24 Months Days Hours I	8 Date of Birth(1 1 - 9 - 67	MM/DD/YYYY) 9. Birth Foreigr Cou	place (State or ntMARYLAND
eland -f show any gnce.	J.	Usual Residence of Decedent 10a State	nie			10d Inside City Limits 1 Yes 2 X No
the Maryland a or 28a-f show	Director	ADT R	Of. Zip Code 21060	_	Citizen of What Count	ry?
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland is and Mental Hygiene and Mental Hygiene and Mental Hygiene are "T is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	by Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Opates.	ecedent of Hispanic Origin? specify Cuban, Mexican, Pue s 2 X No specify:	erto Rican, etc.)	14. Race - Americ White, etc.	te
2036 within 72 hours iene eer than "natur Medical Exami	Completed	15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) Paint	Usual Occupation (Give kind of working life, DO NOT use	retired)	6b. Kind of Business/In	Í
ID 21215-0036 should be filed within 7 and Mental Hygiene 7 is marked other than natic event, the Medical	o Be Con	Anthony J. Longo, Sr.		ame (First, Middle, Mai	Whichard	Zin Codo\2.1060
- p = a = k	ř	Margaret Ann Longo 7507 20a. Method of Disposition 20b. Place of Disposition	E. Furnace	Branch R		urnie,MD
MOFE Pages nent of H aut: If i		1 XBurial 2 Cremation 3 Removal from State Gardens O 4 Donation 5 Other Specify C21, Signic ture of Funeral Service Licensee	f Faith 9		Baltimon	
Physician		7 a. P. T. Enter the disease, or co Aplications that cause The death. Do not enter the fillure. List only one cause of each line.	e and Address of Facility J S. Conklin node of dying, such as cardia	osepn N. og St. Ba ac or respiratory arrest	ltimore, shock, or heart	MD 21224 Approximate Interval Between Onset and
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760, cate be executed physician and	Medical E	W UNPENDED X AMENDED 23a,pt.II,27 pt 10e 19b per fh 23c. If yes, outcome of pregnancy	er me 2860 10	13-06 vt		
	Physician/Me	23h Mas decodent pregnant in the		egnancy	23d. Date of delivery Month D.	ay Year
P.O. E res that the d signed by the be detached	by	Human Immunodoficiones Vin			2 No 3 Proba	
Records The law requirecte has been a	Completed	Chronic hepatitis		24a Was an autopsy performe	prior to co ed? death?	opsy findings available ompletion of cause of
Vital ysician:	To Be Co	25. Was case referred to medical examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 V ER/Outpatient 3		eck only one) ursing Home 5 Re	esidence 6 Other	
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Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the					s) and manner as starte	
To the Howithin 24 h To the Fur	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated 29b. Signature and title of certifier	29c. License number O.C.M.E.	2	29d Date signed (Mon	th, Day, Year)
DR 3111		30 Name and add as of person who completed cause of death (Item 23a) Pamela Southall, MD Assistant Medical Examiner 111 Per	nn Street, Baltimore, N			· · ·
1 .		31. Date filed (Month, Day, Year) SEP 1 3 2006 32 degistrar's Signature	ઇ			
DHMH 17 Rev 1/2		ORIGINAL				

		•	For State Registrar	State of	Maryl		epartme <i>Certifica</i>			and M		giene Reg. No.	006	29033
	J = 5		1. Decedent's Name (First, Middle, La	ast)							2. Date of De	ath		3. Time of Death
	Physicia		Ezekiel (George	- 1	ove I					Month August	Day 20	2006	2:55 pm M
	/Medic Examin		4a. Facility Name (If not institution, gi	ve street and numb	er)		4b. Cit	y, Town, or	Location o	Death		4c. (County of Deat	1
			Laurel Regional Hosp	tal				Laur	e1			Pr	rince Geo	rges
20.	Funeral	100		Sex 7. 1√ M 2 F		rs. last birth	Month	ler 1 Year s Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th y, Year)	9. Birtl Co	nplace (State or Foreign untry)
	Director		247-72-7282	,X1 M 2 U F	62	Υ	rs.				June 18,		Sout	n Carolina
and	*		Usual Residence of Decedent 10a. State 10b. County		10c.	City, Town	or Location							10d. Inside City Limits
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the	28a	Director	10e. Street and Number				10f. 2	ip Code				10g. Citiz	zen of What Co	untry?
with	38 0		7601 Colony Avenue				2	0707				Unite	ed States	America
death	rms 2	Funeral	11. Marital Status	12. Was Decede		n U.S.	13. Was Dec	edent of H	ispanic Orig	gin? (Spe	ecify Yes or No Rican, etc.))- 1	14. Race - Ame Black, White	
after	or its		1 ☐ Never Married 2 Married	1 Yes 2				2 No	Specify:	i, ruento	rican, etc.)		Specify: Bla	
Super	Iral.	d by	3 Widowed 4 Divorced	Year or Date	os:									
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6 5	ked c	To Be	Reynold Love						Anni	emae	Mims			
shou	if Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23a or 28a-f show other traumatic event, If a Medical Examinar must be multified at	-	19a. Informant's Name/Relationship	(Type, Print)		19b.	Mailing Addre	ss (Street a	and Numbe	or or Rura	al Route Numb	er, City or	Town, State, Z	ip Code)
End 2	alth a		Regina C. Love/Wife			760	1 Colony	Avenu	ie Lau	rel	Maryland	2070)7	
es 1 g	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	Domount from St		b. Place of l	Disposition (No. crematory of	lame of r other plac	e)	[Date	20c. Loc	cation - City or	Fown, State
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	Depertment of Health a important: If Item 27 is any injury or other tra		21. Signature of Juneral Service Lice	ensee					s of Facility	•				
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			23a. Part1. Enter the disease, or con shock, or heart lailure. List only	nplications that cau y one cause on eac	sed the d h line.	leath. Do no	ot enter the m	ode of dyin	g, such as	cardiac (or respiratory a	rrest,		Approximate Interval Between Onset and Death
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The law requires that the death certificate be executed	physicien and s the burial-translt	Еха	resulting in death) Last	Due to (or	as a con	sequence o	l):							
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rtificat	ng ph		IF FEMALE:										1	
of the	ed by the attending produced for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco	n 2 □ F	etel death	3 □Ectopic					2	3d. Date of deli Month	very Day Year
e de	the a	sic	1 Yes 2 No	4□Pregnar 9□Unknow		ol death	5 Other (specify)						,
That if	ad by detac		Part II. Other significant conditions	contributing to dea	th but not	resulting in	the undertying	cause civ	en in Part I.		23e. Did t	obacco us	se contribute to	the cause of death?
v requires t	s been signed b	Completed by	Diabetes Mellitus	, and the second		•	,	•			1 🗆	Yes 2[□No 3□Pro	bably 4 JUnknown
5 8	beer	lete									24a. Was	an	24h Were au	topsy lindings available
ב ק פו	e has	Ę									auto perfe	psy ormed?	prior to death?	ompletion of cause of
<u> </u>	ifficate or, pa	ပို	25. Was case referred to medical						26 Place	of Death	1 ☐ Yes	C 1 (1 (1) (1)	1 L Yes	2 □ No
vaicie	s cert	0 B	examiner? 1 ☐ Yes 2 🔀 No	Hospital:	atient	2 ER/Out	patient 3□ I	Oth	ar				G ☐ Other (Spec	(v/v)
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Z AIT	irscte irscte	Certification:	3 Suicide 6 Could not determine	4 286. Place o	Injury - / , etc. (Sp	At home, fari	m, street, fact	ory, office			28f. Location (City or To			ral Route Number,
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DIVISION OF VICE To the Hospital or Attending Physician:	within 24 hours after death. To the Funerei Director: After this certificate has completely filled in by the funeral director, page 2.	Medical	29a. Certifier 1 ☐ Certifying F (Check only one) 2 ☐ Medical Exe	hysicien: To the b miner: On the bas	is of exam	Knowledge, nination and	death occurre or investigation	ed at the tin on, in my o	ne, date an pinion, deal	d place, th occurr	and due to the red at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
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ř	3 ⊢ 8		Do ale	20.0.0		-		03	69-	725				
	1		30. Name and address of person who	completed cause	of death	(Item 23a) (1	Type, Print)	مدرز	0.11	7	4 000	1/2	OFT DA	Du . Jane
	9		DAVID O. r	JYANJ	2500	1 W	10	Con	J.MB	12	~0	205	49	NEW THY
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State

Registrar

SEP 1 3 2006

		1	State of Maryland / Department of Health and Mental Hygiene State Amend item#14,19a,perFH,C859,9/13/06 CTrificate of Death Reg. No. 2006 29034
	Physicia	an	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 4:20 PM
	/Medic Examin	-	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1/a
	Funeral Director		5. Social Security Number 3. Social Security Number 3. Social Security Number 4. Social Security Number 5. Social Security Number 6. Sex 1
	ehow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD n/a Baltimore City 1 ☑ Yes 2 ☐ No
	with the h a or 28a-1 be notifi	Director	10e. Street and Number 2725 Walbrook Avenue 10f. Zip Code 21216 US
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deperment of Health and Mental Hyglene. Deperment of Health and Mental Hyglene important: if item 27 is marked other than "natural", or items 23a or 28a-f show air inportant: if item 27 is marked other than "natural", or items and 15a notiliari and input or other traumatic event, the Medical Examinar must be notiliari and once.	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Midowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Specify: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: 14. Race - American Indian, Black, White, etc. Specify: 15. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.)
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	should be filed and Mental Hygie amarked other umatic event, II	To Be Co	17. Father's Name (First, Middle, Last) William Lee Jones 18. Mother's Name (First, Middle, Maiden Sumame) Bertha Brown Anderson
Maryland	ind 2 shou alth and M 27 fs mar or traumat		19a. Informant's Name/Relationship (Type, Print) Winifred Wallace / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11524 Charlton Drive; Silver Spring, MD 20902
Baltimore,	Pages 1 and of He Int: If Item		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Memorial Park 09/11/2006 Baltimore, MD
Balti	permit. Depertn Imports any inte		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, MD 21217
760,	Physician and winding physician and national sea as the burial-transit	cal Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):
.O. Box 687	at at	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown 9 Unknown 9 23d. Date of delivery 23d. Date of delivery 23d. Date of delivery Month Day Year 9 Year
٥	requires that the de sen signed by the a hould be detached t	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
of Vital Records,	The law ate has b page 2 s	Completed	Deniel Jacker 24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 1 Yes 2 No
of Vita	Physician: Th rthis certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1
Division	tending leath. tor: After the fune	Certification:	27. Manner of Death 1 Accident S Pending investigation 3 Suicide 4 Homicide Homicide Suicide Suic
۵	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	To the H within 24 To the F complete	Medical	29b. Signature and title of certifier 29c. License number 29d. Date signed (Mogtin, Day, Year) 33 (90) 3 (90)
	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 401 Marfardave Kalfreid Mc 2/2/3
	St Regist	ate trar	31. Date filed (Month, Day, Year) SEP 1 3 2006 32 Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend Item 23a, PtII, per dr., C860, I0/04/06dhb
State of Maryland / Department of Health and Mental Hygiene
Amend Items 4b, 25, 27, 28a-f per initiale of Dealth 9/06dhb
Reg. No. 2008 Mental Hygiene 2006 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) SEPTEMBER 8 2006 **Physician** LESSER 12:07 A M BERNICE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE Pikesville JEWISH CONVALESCENT CENTER BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, Year) 05/28/1915 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2√□ F 212-01-3695 MD Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show Item 27 is marked other then "neturel", or iteme 23a or 28a-f show other traumatic event, the Medical Exercipar must be notified at 1 ☐ Yes 2 No Funeral Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7920 SCOTTS LEVEL ROAD 21208 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify WHITE Completed by 3

Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Il Hygiene. SECRETARY LAW OFFICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental ABEL DAGURT DANIEL YETTA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3731 GREEWAY LANE - OWINGS MILLS, MD 21117 GARY LESSER / SON of Health a 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Dogation 5 ☐ Other (Specify) ō Department of Importent: If eny injury of once. 5 ☐ Other (Specify), ANSHE EMUNAH AITZ CHAIM 09/10/2006 BALTIMORE, M.D 21. Signature of Funeral Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208
Approximate Interval Between Onset and Death 3a. Part1. Enter the disease, or complications bet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one case on each line. Immediate Cause (Final disease or condition resulting in death) Physician rotic /Medical uence of): Due to (or as a cons Examiner SPIRK TOON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner sicien and or Attending Physicien: The law requires that the death certificate be executed attending physicien for use as the buria P.O. Box 68760, CERTIFICATION APPRINCED BY MEDICAL EXAMINER use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by phagra, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been sig Fractured Femur 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has I irector, page 2 s 1 ☐ Yes 20 No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို 1X Yes 2510 this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Medical Certification: 1 Catural 5 Pendina Subject fell 05/30/06 Unknown M 1 ☐ Yes 2 No investigation 2X Accident I Director: / 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, within 24 hours after of To the Funeral Direct completely filled in by determined building, etc. (Specify)

Convalescent Center

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 4 Homicide ro the Hospital 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D-16090 9,8,06 completed cause of death (Item 23a) (Type Print) emore Md 21208

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

SFP 1 3 2006

32. Pagistrar's Signature

				State of Maryland / Department of Health and Me 1- State Registrar Certificate of Death		ne No.2006 29036
		Physici /Medic		1. Decedent's Name (First, Middle, Last) 2 Conthia G. Matthews - Williamson	2. Date of Death Month	Day Year 18:35 M
		Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death
		Funeral	-	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8	B. Date of Birth (Month, Day, Ye	Baltimore 9. Birthplace (State or Foreign
		Director		219-94-3749 Tall 42 Yrs.	03/36/1	964 Country) MD
		land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
		e Mary ta-feh	ctor	MD Baltimore	·	1 ☑ Yes 2 ☐ No
		within 72 hours after death with the Maryland ene. then "naturel", or Items 23a or 28e-f ehow he Madical Evaminar must be notified at	by Funeral Director	100. Street and Number HTDH Greenspring Ave. Apt. B3 21209		Citizen of What Country?
		death ms 23	nerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specifit Yes, specify Cuban, Mexican, Puerto Ri		14. Race - American Indian, Black, White, etc.
10	36	or Ite	y Fui	Armed Forces? 1 Never Married 2 Married 1 Yes, Specify Cuban, Mexican, Puerto Ri 1 Yes, 2 Married 1 Yes, 2 Married 1 Yes, Sive 1 Yes, 2 Married 1 Yes, 2 Married 1 Yes, Specify:	ican, etc.)	Specify: Black
~	5-0036	ture!	ed b	3 Widowed 4 Norced Year of Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation		b. Kind of Business/Industry
0	215	d within 72 piene. r then "ne	npiet	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)		1 . 11 . 11
1	d 21	I Hygien other th	Be Completed	12. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Mai	Wriel Matthews, Inc
	lan	e d ta	To Be	Anthony R. Matthews SR. Helen J.		
	Maryland	and		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural in the Informant's Name (Street and Number or Rural in the Informant's Name (Name	Route Number, C	
0	_	ges 1 and 2 t of Health If Item 27 in		20a Method of Disposition 20b. Place of Disposition (Name of Da		(1) 21207 c. Location - City or Town, State
1	E E	Pages nent of I ant: If It		1 ⊠ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Cod \ awn Cometery, crematory or other place) Wood \ awn	12006 B	paltimore, MD
1	Baltimore,	permit. Pages Department of Important: If I eny Injury or o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Your C. Greene Fune	eal Svc	
2		<u></u>		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or		
		Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition NIDWY SCLURGS (S		Interval Between Onset and Death
		/Medical Examiner		resulting in death) Due to (or as a consequence of):		VUUVIVIS
		LAdillilei	ē.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of).		
		outed nd ransit	Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events c.		
	,092	death certificate be executed e attending physicien and of for use as the burial-transit	ical Ex			
	687	g phys				
2.	Box	leath certifical attending phy I for use as th	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of delivery Month Day Year
3	0.		Physician/Med	1 Yes 2 No 9 Unknown 5 Other (specify)		
1	O.	The law requires that the Ite has been signed by th page 2 should be detache	by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
2	ord	w requires that been signed k should be det	eted	HIV DISTAIL	1 🗆 Yes	2 DNo 3 Probably 4 Unknown
2	Recor	ne law shasb ge 2 sl	Completed		24a. Was an autopsy performe	
-	ital	ilcien: Th certificate rector, pag	0	25. Was case referred to medical 26. Place of Death		No 1 □ Yes 2 □ No
20	of Vital	Physicien: this certific ral director.	ToB	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom	e 5 Residence	ce 6 DOther (Specify) NOSPLY
3		Attending Physic death. actor: After this by the funeral di	tion	27. Mamer of Death 1 CNatural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 1 Pending 2 Accident investigation 48c. Injury at Work? 1 Yes 2 No	od. Describe now	injury occurred
Williamsch	Division	r Atter ler dea Irector I by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
3	Q	pital o			nd due to the caus	ca/c) and manner as stated
		To the Hospital or Attending Physicien: The i within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.		
		Withii comp	Ž	29b. Signalars and title of certifier 29c. License number 80 C 8 3 0 3	29d	Date signed (Month, Day, Year)
		1		29b. Signal of and title of certifier 29c. License number 8 58 3 0 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Brint) Amon Charles My 660(N Charles St 13 m)	3	- A 7 /2
		8		Agnon Charles by 6601 N. Charles St Box	more	vis cicay
		St Regist	ate rar	31. Daté filed (Month, Day, Year) Registrar's Signature		

			For State Registrar	State of	f Marylar		artment of H		, ,	iene	5 20037
	Physici		1. Decedent's Name (First, Middle, La Gerlieve J. Mos						2. Date of Dea		3. Time of Death 7:21 AM M
1	/Medic Examir		4a. Facility Name (If not institution, giv		mber)		4b. City, Town, or			4c. County of De	
	Funeral Director		5. Social Security Number 6. S 237–58–2837		7. Age (In yrs.	last birthday) 2 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Day	Year) 9. B	inthplace (State or Foreign Country) th Carolina
	se Maryland Ba-f ehow	Director	Usual Residence of Decedent 10a. State 10b. County MD Howard			ty, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	ath with the 23e or 21		10e. Street and Number 8601 Golden St				10f. Zip Code	21045		0g. Citizen of What 0	•
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "naturel", or iteme 23s or 28s-f ehow aumatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Dece Armed Fo 1 Tes If Yes, Giv Year or Di	2X No ∕e	į .	Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2∑ No	spanic Origin? (: n, Mexican, Pue Specify:	Specify Yes or No- no Rican, etc.)	14. Race - An Black, Wh Specify: b	nite, etc.
21215-003	within 72 ho ene. than "natur he Medical	Completed by	15. Decedent's E (Specify only highest gra-			(Give	tent's Usual Occupa kind of work done of DO NOT use retired teache	luring most of wo)	orking	16b. Kind of Busines	•
Maryland 2	9 7 5	To Be Co	17. Father's Name (First, Middle, Last, Wayland Edwin					18. Mother's Na	ime (First, Middle, l	Maiden Sumame)	
	es 1 and 2 should b of Health and Ment fitem 27 is marked r other traumatic e		19a. Informant's Name/Relationship (Berene McKay/daug 20a. Method of Disposition		205.1	5213	ng Address (Street a Wagonshed sition (Name of		Owings M		21117
Baltimore,	permit. Pages Department of h important: If ite eny injury or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ② Donation 5 ☐ Other (Specif	y) _	State	cemetery, crer	natory or other plac	ļ		20c. Location - City of	
Ba	Depring Park		21. Signature of Emeral Service Licer RONAL C S 23a. Party. Enter the disease, or come shock, or heart failure. List only Immediate Cause (Final	100	irector aused the dear	Ba	ltimore.	MD 212	01	Baltimore	Approximate
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a	or as a consec		ic CA	ncer			Interval Between Onset and Death
8760,	icate be executed physicien and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a consec						
O. Box 6	ath certi	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		inth 2 ☐ Feta ant at time of c	aldeath 3□	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
rds, P.	w requires that the de been signed by the e should be detached f	þ	Part II. Other significant conditions of	ontributing to de	ath but not res	sulting in the u	nderlying cause give	on in Part I.	23e. Did to	/	to the cause of death? Probably 4 □Unknown
al Records,		Completed							24a. Was a autops perfore 1 🗆 Yes	med? prior to	autopsy findings available completion of cause of
on of Vital	Attending Physician: Thir death. ector: After this certificate by the funeral director, pag	ıtlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date (Mont	npatient 2 of Injury	ER/Outpatier 28b. Time of Injury	28c. Injury Work	Or: 4 ☐ Nursing		ne) ence 6 (Tother (Sp ow injury occurred	ecity) Hospie
Division	To the Hospital or Attendin within 24 hours efter death. To the Funerel Director: At completely filled in by the fur	Certification:	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place	of Injury - At h ng, etc. (Speci	ome, farm, str fy)	eet, factory, office		28f. Location (Si City or Town	treet and Number or I n, State)	Rural Route Number,
	To the Hospital or within 24 hours efte To the Funeral Dir completely filled in	Medical	one)	ysician: To the niner: On the ba and mann	asis of examina	owledge, deatl ation and/or in	estigation, in my op	oinion, death occ	urred at the time, d	ause(s) and manner a ate and place, and du	ue to the cause(s)
	Twit To	-	29b. Signature and title of certifier	my /	lily.	und	29c. License			effentu	11th, Day, Year) - 8, 2006
	Sta	te	30. Name and address of person who A. R. Ley 31. Date filed (Month, Day, Year)	G. BMC	e of death (Ite)	m 23a) (Type,	Charles	St. R	halto. 1	nd Zizo	n/
	Registr	_	SEP 13	2006	Rolling	D. L	cons				

State of Maryland / Department of Health and Mental Hygiene 2005 29038 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Year Physician 4:30 AM McDaniel SCRTEMBER Mary 2000 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner AMNE ARUNDEL ANNAPULIS, MARYLAND MEDUAL LINIER ARVNOEL HNNE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Jan 15 1919 6 Sax 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** West Virginia 1□M 2XF Yrs. 579-26-9726 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10h County 10d. Inside City Limits or 28a-f ahow Hygiene. other than "natural", or items 23a or 28e-f ahov ent, the Medical Examinar must be notified at Maryland Pasadena Anne Arundel 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21122 USA 9199 Firefly Run Funeral Pages 1 and 2 should be filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: ģ white 3XXWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Household Homemaker othar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fils Department of Health and Mental Hy Important: if Item 27 is marked oth any linury or other traumatic event opca. Be Yambor Frances Stehanie John Garay ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9199 Firefly Run Pasadena MD 21122 Linda S McAvoy daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State Baltimore Maryland Metro Crematory Inc. 9/13/06 4 ☐ Donation j 5 ☐ Other (Specify) 21. Signature of Funeral Savice Liceuse 22. Name and Address of Facility Stallings Funeral Home P.A. Þ 3111 Mountain Road Pasadena MD 21122 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or compliations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only or en ause on each line. Immediate Cause (Final disease or condition resulting in death) OBSTRUCTION Physician LARGE BOWEL 10 days /Medical Due to (or as a consequence of) Examiner PECAL IMPACTION if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. ettending physicien by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 □Yes 2 □No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ♣No 24a. Was an autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 EN/Outpatient 3 DOA မ 1 Yes 2 No efter death.
Director: After this d in by the funeral d 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral D completely filled i filled 125 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ş 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 00056658 M.P. Jeptember 12,2006 10 ANNE ARVNOEL MEDKAL CENTER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABRAHAM 2001 Parkwan Medical ANNAPOLYS 21401 31. Date filed (Month, Day, Year) 32. Registrar's Signature. Registrar

		State of Maryland / Department of Health and N 1- State Registrar Certificate of Death	Mental Hyg	•	29039
Physic /Med		1. Decedent's Name (First, Middle, Last) Ella Grace McGhee	2. Date of Deat. Month	10 2006	3. Time of Death 2220 M
Exam	iner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death University Specimity Hospial 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, March 22	4c. County of Death N/A Year) 9. Birthp	
Directo		217-26-9501	March 22		TN Od. Inside City Limits
the Maryl 28a-f sho	rector	Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code	10	0g. Citizen of What Cour	1 ⊠ Yes 2 □ No
eath with na 23a or must be	Funeral Director	600 Light Street 21230 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	pecify Yes or No-	USA 14. Race - Americ	an Indian.
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural; or Itema 23a or 28a-f show any Injury or other traumatic event, the Medical Examinat must be notified at	by	3 Widowed 4 Divorced Year or Dates:		Black, White, Specify: Wh	ite
1215-0036 within 72 hours af and. hatural; or than "natural; or a Medical Exam	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) College (1·4or 5+)	king	16b. Kind of Business/In	
land 2	To Be Co	17. Father's Name (First, Middle, Last) Mittaball Looph	ne (First, Middle, M Unknowr	Maiden Sumame)	s c i y
, Maryland and 2 should be file asith and Mental Hy n 27 is marked oth the traumatic event		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run 19c. Mailing Address (Street and Number or Run 19d. Mailing Address (Street	adena, MI	21122	
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Ball permit Depart Import		3111 Mountain Ro	oad, Pasa		122
Physician /Medica		23a. Part 1. Enter the disk se, or complications that cause of the death. Do not enter the mode of dying, such as cardiac shock, or heart failur. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	Se	951,	Approximate Interval Between Onset and Death
3760, A tabe executed the best of table and table burial-transit en	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Di cib.etco mellitus Due to (or as a consequence of): Chronic atrial fibrill Due to (or as a consequence of):	ation		yn,
Division of Vital Records, P.O. Box 68 to the Hospital or Attanding Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ 9 □ Unknown		23d. Date of delive Month	ery Day Year
rds, P.(quires that II on signed by uid be detac				pacco use contribute to the	ne cause of death? ably 4-Unknown
f Vital Record ysician: The law requir is certificate has been si director, page 2 should	Completed			y prior to condeath? No 1 □ Yes	psy findings available inpletion of cause of
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Hospital of the Hours at Funeral C	edical Ce	29a. Certifier (Check only one) 1. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, (Check only one)	, and due to the ca rred at the time, da	ause(s) and manner as si ate and place, and due to	ated. the cause(s)
To the within 2 To the comple	Med	29b. Signature and title of certifier Prochte mi) 29c. License number D 3 4 9 7 4	29	9d. Date signed (Month,	Day, Year)
3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARU MEHTA MD 601 Sounds Charles chood	Balti	mere M	221230
S Regis	tate trar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (HARU MEHTA, MD 601, South Charles Street) 31. Date filed (Month, Day, Year) SEP 1 3 2006	,		

Director 217 09 5587 1 M 2 S F 93 Yrs. Months Days Hours Min. Sept. 7, 1913 Ma Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland N/A Baltimore 10b. Street and Number 10c. Street and Number 21225 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Black, Wh. Sept. 7, 1913 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Black, Wh. Black, Wh. Sept. 7, 1913 Marital Status 14. Race - Armed Forces? 15. Was Decedent of Hispanic Origin? (Specify Yes or No-Black, Wh. Black, W	ath irthplace (State or Foreign Country) aryland 10d. Inside City Limits 1 Yes 2 No Country? nerican Indian, nite, etc.
Au Facility Name (If not institution, give street and number) Ab. City, Town, or Location of Death Ac. County of Death	inthplace (State or Foreign Country) aryland 10d. Inside City Limits 1 \$\mathbb{X}\$ Yes 2 \$\mathbb{N}\$ No Country? nerican Indian, nite, etc.
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Armed Forces? If Yes, specify Cuban, Mexican, Puèrio Rican, etc.) Black, What I was a status of the state of	hite
Specify: Will a substitute of the substitute of	:s/Industry
15. Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed)	
Specify: Will Specify Will Specif	
To Barbara Sash 17. Father's Name (First, Middle, Last) James Kaiser 18. Mother's Name (First, Middle, Maiden Surname) Barbara Sash	
James Kaiser James Kaiser Dar Dara Sasn James Kaiser J	, Zip Code)
Wayne D. Morris / Son 4705 Charleston Street Baltimore, Mary	land 21225
20a. Method of Disposition 20b. Place of Disposition (Name of commeter), crematory or other place) 20c. Location - City of commetery, crematory or other place)	
Cedar Hill Cemetery 9/9/2006 Baltimore, 22. Name and Address of Facility Gonce Funeral Servi	*
चै है है है है । Quome gnomusully 4001 Ritchie Highway Baltimore, Mar	
23a. Payl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Physician METABLIC ACIDOSIS	Approximate Interval Between Onset and Death
/Medical resulting in death) Due to (or as a consequence of): REWAL FAILURE	Few
Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
That initiated events resulting in death) Last Due to (or as a consequence of):	
Spannows	delivery Day Year
The state of the s	to the cause of death? Probably 4 Unknown
24a. Was an autopsy performed? 1 Yes 2 No 1 Yes	autopsy findings available o completion of cause of ?
- 00 10	35 2 NO
Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Sp.	эвсіfy)
building, etc. (Specify)	Rural Route Number,
29a. Certifier 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (Check only 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner	as stated. ue to the cause(s)
and manner stated. 29c. License number 29d. Date signed (Mo	nth, Day, Year)
00062634 917/06	
30. Na and address of person who completed cause of death (Item 23a) (Type, Print) MATEEN AWAN, 2717 HAMMONDS FERRY ROAD BALTIMORE MD 2	21227
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar SEP 1 3 2005	

JOHN MURPHY

Please Type or Print in Black Indelible Ink

UNK UNK State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg No. Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day September 8, 2006 1540 hrs Medical Examiner Joseph John Murphy 4b City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) 1600 blk of Wicomico Street Baltimore 8. Date of Birth (MM/DD/YYYY) 9 Birtholace (State or If Under 1 Year | If Under 24Hrs 5 Social Security Number 7. Age (In yrs. last birthday) **Funeral** oreign Months Davs Hours Director Country) Masyland August 29, 1968 38 219-04-8106 1 X M Usual Residence of Decedent 10d Inside City Limits 10a State 10b. County 10c. City, Town or Location any 1 X Yes 2 No 28a-f show Maryland Anne Arunde Brocklyn Park hours after death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number notified at "natural", or items 23a or USA Alden Street 504 21225 Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 8lack Funera 11 Marital Status 12. Was Decedent Ever in U.S Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 X Married Yes Specify. White f Yes, Give Year 4 Divorced Yes 2 X No specify: Widowed þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within 72 I nent of Health and Mental Hygiene ant: If item 27 is marked other than "I or other tranmatic event, the Medical E Baltimore, MD 21215-0036 Construction 11 Construction Worker 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Be Charles Murphy Sr. Ewing 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) ဥ Lexington, SC 29073 Brother Vernon Drive Charles Murphy 20c. Location - City or Town, State 20a. Method of Disposition 20b Place of Disposition (Name of cemetery, Date crematory or other place) 1 Burial 2 Cremation 3 Removal from State Hanvier, MD permit. Page Department o Important: injury or oth Anatomy Gifts Registry September 10,2006 4 Donation 5 Other Specify: 22. Name and Address of acility Ancturny Gifts Registry 21. Signature of Funeral Service Licenses 0 7522 Connelley Drive suite P. Hanover, MD 23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Heroin intoxication and cocaine use Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examiner (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): uires that the death certificate be executed and Physician/Medical attending physician afor use as the burial -X UNPENDED AMENDED item#23a,27,28a-f,perME,g859.9/20/06 TT Division of Vital Records, P.O. Box 68760, 23d Date of delivery IF FFMALE 23c If yes, outcome of pregnancy 23b Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? ģ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a, Was an 24b Were autopsy findings available autopsy prior to completion of cause of certificate has death? performed? ✓ Yes 2 1 V Yes 25. Was case referred to medical 26 Place of Death (Check only one) Hospital or Attending Physician: Be examiner? Hospital. Other₄ Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 ✓ Other: Scene this 1 V Yes No 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Manner of Death Certification: a 24 hours after deam are Funeral Director: A Natural Pending 1 Yes 2 X No Fnd 9/8/2006 Fnd 3:35 pm unknown 2 Accident Investigation 28f Location (Street and Number or Rural Route Number City or Town, State) 1600 Blk. Wicomico St. Baltimore, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be Suicide (Specify) found in back of a pick-up truck determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29b. Signature and 29c License number 29d Date signed (Month, Day, Year) tle of certifie OCME September 9, 2006 o completed cause of death (Item 23a) 30. Name and add Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 pple MD. 31. Date filed (Month, Day, Year) 2006 Registrar's Signature State

Registrar

06-06697 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Derrick Antonio Miller 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ tonio Month Day September 6, 2006 2143 hrs Medical Examiner 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** Johns Hopkins Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Social Security Number 7. Age (In yrs. last birthday) **Funeral** mare Min 979 Director -96-4235 1 V M 2 F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County NIA 1 V Yes 2 No Ma or 28a-f show or items 23a or 28a-f shormust be notified at once. hours after death with the Maryland Director 10g. Citizen of What Country 10e Street and Number 10f. Zip Code USA 2 12. Was Decedent Ever in U.S Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black 11. Markal Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 Never Married Married 2 V No Yes Divorced If Yes, Give Year 1 Yes 2 No specify: Widowed ⋧ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Kind of Business/Industr Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages I and 2 should be filed within 72 Paner of Health and Mental Hygiene ant: If item 27 is marked other than "eor other traumatic event, the Medical E 12th MD 21215-0036 striber 18 Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt's Name/Relationship (Type Method of Disposition 20b. Place of Disposition (Name of cemetery Baltimore, crematory or other place) Removal from State Department of I-Important: If i 2 Cremation 3 curmet MT. Donation 5 Other Specify 22. Name and Address of Facility gnature of Funeral Service Lice Part I Enter the disease, or complication.

Called E. List only one cause on each line

Guns complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and /Medical Death a Gunshot Wounds (2) of Head Immediate Cause (Final disease **Examine** or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical UNPENDED AMENDED Box 68760, IF FEMALE phys the b 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. ģ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) To the Hospital or Attending Physician: 25 Was case referred to medical Other₄ Nursing Home 5 Residence 6 Other DOA this 1 V Yes 28a. Date of Injury (Month, Day, Year) Sep 6, 2006 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Subject shot 2123 hrs Natural 1 Yes 2 V No 5 Pending Director: 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 6 Could not be or Town, State) 600 BlockN Montford Ave, Baltimore, MD Suicide determined (Specify) Sidewalk 4 V Homicide 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the

Registra DHMH 17 Rev 1/2001 OCMF 2006

State

29c License number

O.C.M.E.

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

September 7, 2006

and manner stated

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

Patricia Aronica-Pollak MD.

31. Date filed (Month, Day, Year) 2006

			1 - For State Registrar	State of M	laryland / D	epartment Certificate			nd Me		jiene 	מֿחה	2.0	ሀነ 3
	Physici /Medic		1. Decedent's Name (First, Middle JOSSPH	, Last)		\mathcal{W}	IIK!	HAI		2. Date of Dea Month	Day	Year 7006	3. Time o	A M
	Examir		4a. Facility Name (If not institution The Johns Hop	oking Hospi	141	BAH	IMO	Location of			4c. Cou		ore City	
	Funeral Director		5. Social Security Number none Usual Residence of Decedent	6. Sex 1 M 2 □ F	ge (In yrs. last birt 70	hday) If Under Yrs. Months	Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day March 16	, Year)	9. Birthp Cour	place (State of htry) Egypt	or Foreign
	Maryland	tor	10a. State 10b. County	ne Arundel	10c. City, Town	or Location	5	Severn				1	0d. Inside C	ity Limits
	3a or 28	i Dire	10e. Street and Number 1778 Sea Pine Circl	e		10f. Zip	Code	2114	44		0g. Citizen	of What Cour		
336	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental tyglene. Depertment of Health and Mental tyglene. Important: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f show important: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f show any fujury or other traumatic event, if a Medical Examinar must be notified at ances.	by Funeral Director	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces	No	13. Was Deced	. /	spanic Orig n, Mexican, Specify:	in? (Spec Puerto R	cify Yes or No- lican, etc.)	E	Race - Americ Black, White, acify:		
Maryland 21215-0036	within 72 hor iene. than "nature it e Medice	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) unk.	college (1-4or		Decedent's Usua (Give kind of wor life. DO NOT us	k done di e retired)	tion uring most known	of workin	g	16b. Kind o	f Business/In unkn		
yland 2	ould be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, I	ast) Inknown				18. Mother	's Name	(First, Middle,	Maiden Sun Inknown			
ž	and 2 sho ealth and n 27 is m		19a. Informant's Name/Relationsh Mr. Waffaii Sale			Mailing Address 1778 Sea				Route Number		wn, State, Zip	Code)	
Baltimore,	Peges 1 a nent of Hei int: If Item iry or othe		20a. Method of Disposition 1 Surial 2 Cremation 4 Donation 5 Other (Sp.	3 □Removal from State	20b. Place of cemeter	Disposition (Namy, crematory or of	ther place	10	Da	10		on - City or To arksville,		d
Balti	permit. Depertri Importa eny Inju		21. Signature of Funeral Service I	icensee July f	M01293	22. Name and	d Address lack Fu	of Facility	lome,	P.A. ike Ellicott	City. MI	21043		
	Physician /Medical Examiner		23a. Part1. Errifer the disease, or shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)	a. HYPC	ed the death. Do n line.)X2ml s a consequence of	A	e of dying	, such as c	cardiac or	respiratory arr	est,		Approximat Interval Bet Onset and	tween Death
8760,	icate be executed physicien and s the burial-transit	cai Examiner	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	s a consequence o									
P.O. Box 68	death certif e ettending od for use a:	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e of pregnancy 2 Fetal death at time of death	3 ☐ Ectopic pre		13	33			Date of delive		Year
	The law requires that the site has been signed by the page 2 should be detache	þ	Part II. Dther significant conditio	ns contributing to death	but not resulting in	the underlying ca	ause give	n in Part I.			bacco use c es 2 □ No	ontribute to th		death? Unknown
Division of Vital Records,	: The law re cete has bee , page 2 sho	Completed								24a. Was a autops perform	V	death?	psy findings mpletion of a	available ause of
\	ysician is certifi director	o Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \)	Hospital:	ient 2 ER/Out	tpatient 3□ DO	Other	_		(Check only or e 5 ☐ Reside		Other (Specifi	w)	
ion of	To the Hospital or Attending Physician: The I within 24 hours efter death. To the Funeral Director: After this cardificate ha completely filled in by the funeral director, page	ation: T	27. Manner of Death 1 Autural 5 Pending 2 Accident investig	ation			Bc. Injury Work		28	Bd. Describe ho	-		<u> </u>	
Dİ <u>X</u> i	Ital or Att rs etter de ral Direct led in by t	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 289. Place of in building, e	njury - At home, far tic. (Specify)					Bf. Location (Si City or Town	n, State)			nb er ,
	To the Hospital within 24 hours e To the Funeral C completely filled	edical	29a. Certifier 1 Certifying (Check only 2 Medical is	Physician: To the bes xamilier. On the basis and manner s	of examination and	, death occurred a Vor investigation,	at the time in my opi	e, date and inion, death	place, ar occurred	nd due to the c d at the time, d	ause(s) and ate and plac	manner as si e, and due to	ated. the cause(s	s)
)	To the withir To the comp	Me	29b conature and title of certifier	Y	ND		License	number	00	1	9d. Date sig	ned (Month,	Day, Year)	
	2	1	ame and address of	Who composition of	death (Item 23a) (Type, Print)	HW	OLFS	ST	BAL	TIMO	er m	NS 1	287
	Sta Registr		31. Date filed (Month, Day, Year)	<i>M</i>	trar's Signature	Course								

		•	For State Registrar	State of M	laryland / [ent of H ate of L		Ment	al Hygier		29044
			1. Decedent's Name (First, Middle, L	ast)						ate of Death	Day Year	3. Time of Death
	Physici /Medic		SYLVIA	В			MANDY		SE	TEMBER	9 2006	7:15A M
	Examin		4a. Facility Name (If not institution, gi					Location of De	ath		4c. County of Dea	
			7121 PARK HEIGHT				BALTIM	ORE If Under 24 H	Irs I n n	ato of Righ	N/	
	Funeral Director			Sex 7. A	ige (In yrs. last bii 87	Yrs. Mon		Hours M	in. 0.1	ate of Birth fonth, Day, Yea /30/191	ar) 9. Bir	thplace (State or Foreign ountry)
		ŀ	Usual Residence of Decedent		- 07				UI,	7 307 131	J	TID .
	ehow		10a. State 10b. County	-	10c. City, Tow	n or Location						10d. Inside City Limits
	e Ma	5	MD	N/A	В	ALTIMO	RE					Y☐ Yes 2☐ No
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or iteme 23s or 28s-f show or other traumatic event, Its Medical Examinat must be notified at	al Director	7121 PARK HEIGHT	TS AVENUE	APT. 304		. Zip Code 21215			10g. (U.S.A.	ountry?
	r dea	Funeral	11. Marital Status	12. Was Deceden Armed Forces	?	13. Was D	ecedent of Hi specify Cuba	spanic Origin? n, Mexican, Pu	(Specify) erto Rican	es or No- , etc.)	14. Race - Ame Black, Whit	
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 🎇 Widowed 4 ☐ Divorced	1 ☐ Yes 2X If Yes, Give Year or Dates		1 🗆 Y	s 2 No	Specify:			Specify:	WHITE
21215-0036	ture!		15. Decedent's E			. Decedent's	Usual Occupa	ition		16b.	Kind of Business	/Industry
215	7 nic 72	plet	(Specify only highest gi Elementary/Secondary (0-12)	rade completed) College (1-40)		(Give kind o	f work done o T use retired,	uring most of v	working			•
212	d with	Completed	Liententary/Secondary (0-12)	1	HO	MEMAKE	R			0	WN HOME	
	al Hy d other	Be	17. Father's Name (First, Middle, Las	st)		D: T.C				t, Middle, Maid	len Sumame)	1001110
Maryland	d 2 should be filed within h and Mental Hygiene. 7 is marked other than "traumatic event, the Me.	ဥ	NATHAN 19a. Informant's Name/Relationship	(Type, Print)	198	BLIS		SARA and Number or		te Number, Cit	y or Town, State,	ABRAMS Zip Code)
	l and 2 s leath ar m 27 is her trau		SARAH KERN / DAU		50		H FRON			ILADELP	HIA, PA	19147
Baltimore,	Pa ne		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Special Control of Control o		cemete	ry, crematory	or other place	0NG 09/			Location - City or	
Balt	Departicular Depar		21. Signature of Funeral Service Lice			4					& BROS. ESVILLE,	, INC. MD 21208
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	mplications that causely one cause on each	ed the death. Do	not enter the	mode of dying	, such as card	liac or resp	oratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			TATE	1	TANO	no A			Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or a	s a consequence	ol):		_	7			
1	Lxammer	_	Sequentially list conditions,				ecod	6				
	led sit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequence	or):						
	sate be executed obysicien and the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or a	s a consequence	of):						
8760,	sicier sicier	dicai E		d								
89	ificate g phy as the	edic		U								
Вох	leath certific attending pl	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregnancy 2 Fetal death	3 DEctor	ic pregnancy				23d. Date of de	livery
O. B	he deat the att	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		at time of death		r (specify)				Month	Day Year
P.O.	res that the digned by the be detached		Part II. Dther significant conditions	contributing to death	but not resulting i	in the underly	ing cause give	n in Part I.	2	3e. Did tobacc	o use contribute t	o the cause of death?
Records,	puires n sign ald be	d by								1 ☐ Yes	2, NO 3 P	robably 4 Unknown
00	8 9 5											
Re	s been s should	et							- 2	4a. Was an	24b. Were a	utopsy findings available
ital	The law rate has be sage 2 sh	omplet							-	autopsy performed	death?	utopsy findings available completion of cause of
	The lay ate has page 2	se Completed	25. Was case referred to medical					26. Place of D	_ 1	autopsy performed Yes 2	death?	utopsy findings available completion of cause of 2 No
-	(0)	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpa	tient 2□ER/O	utpatient 3[DOA Othe		1 Death (Che	autopsy performed Yes 2	death?	20 No
	(0)	To Be	examiner? 1 Yes 2 No 27. Manner ol Death	Hospital: 1 ☐ Inpa 28a. Date of In (Month, L		utpatient 3[Time of Injury	DOA Othe	er: 4 Nursing	Death (Che	autopsy performed Yes 2	death? No 1 Yes 6 Other (Spe	20 No
sion of	(0)	To Be	examiner? 1 Yes 2 No 27. Manner ol Death 1 Natūral 5 Pending 2 Accident investigati	28a. Date of In (Month, D	jury 28b.	Time of Injury M	28c. Injury Work	er: 4 Nursing	Death (Cha g Home 28d. [autopsy performed Yes 2 cck only one) S Pestuence Describe how in	death? 1 Yes 6 Other (Spe	city)
vision	(0)	To Be	examiner? 1 Yes 2 No 27. Manner ol Death 1 Natural 5 Pending	28a. Date of In (Month, D		Time of Injury M	28c. Injury Work	at	Death (Che g Home 28d. (autopsy performed Yes 2 cck only one) S Pestuence Describe how in	death? No 1 Yes 6 Other (Spe	20 No
Division	(0)	Certification; To Be	examiner? 1 Yes 2 No 27. Manner ol Death 1 Natūral 5 Pending 2 Accident 3 Suicide 6 Could not determine 29a. Certifier (Check only) 2 Medipel Examiner	28a. Date of In (Month, E of building, Physician: To the basis	pury 28b. njury - At home, Isetc. (Specify) st of my knowledg of examination ar	Time of Injury M arm, street, fa	28c. Injury Work 1 1 ctory, office	at ? /es 2 No	Death (Che g Home 28d. L	autopsy performed Yes 2 2 ack only one) 5 Aesidence Describe how in occation (Street lifty or Town, St. use to the cause	death? No 1 Yes 6 Other (Spe siyury occurred and Number or R ate)	crify) ural Route Number,
Division	(0)	To Be	examiner? 1 Yes 2 No 27. Manner ol Death 1 Natural 5 Pending investigate 3 Suicide 6 Could not determine 29a. Certifier 1 Certifying F	28a. Date of In (Month, £) 28e. Place of I building.	pury 28b. njury - At home, Isetc. (Specify) st of my knowledg of examination ar	Time of Injury M arm, street, fa	28c. Injury Work 1 1 ctory, office	at ?? fes 2 No e, date and plainion, death of	Death (Che g Home 28d. L	autopsy performed' Yes 2 2 ack only one) 5 Residence Describe how in cocation (Street inty or Town, St. use to the cause the time, date a	death? No 1 Yes 6 Other (Spe siyury occurred and Number or R ate)	s 2 No ocify) ural Route Number, s stated. e to the cause(s)
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Division	To the Hospital or Attanding Physician: within 24 hours alfar death. To the Funeral Director: After this certifical completely filled in by the tuneral director,	Certification; To Be	examiner? 1 Yes 2 No 27. Manner ol Death 1 Natural 5 Pending investigate 3 Suicide 4 Homicide 6 Could not determine 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and add/ests of person who	28a. Date of In (Month, Don be done) 28e. Place of I building. 28e. Place of I building. 28e. Place of I building.	jury 28b. njury - At home, lietc. (Specify) sit of my knowledg of examination arstated. death (Item 23a)	Time of Injury M Arm, street, fa e, death occur and/or investigs (Type, Print)	28c. Injury Work 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	at ? (es 2 \sum No e, date and plainion, death or number	Death (Che g Home 28d. [Che che che che che che che che che che c	autopsy performed' Yes 2 2 ack only one) 5 Residence Describe how in cocation (Street inty or Town, St. use to the cause the time, date a	death? No 1 Yes 6 Other (Spe sjury occurred and Number or R ate) o(s) and manner a and place, and death	s 2 No ocify) ural Route Number, s stated. e to the cause(s)
Division	(0)	Certification; To Be	examiner? 1 Yes 2 No 27. Manner ol Death 1 Natural 5 Pending investigate 3 Suicide 4 Homicide 6 Could not determine 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and add/ests of person who	28a. Date of In (Month, Don be d 28e. Place of I building, I and manner sand m	jury 28b. njury - At home, lietc. (Specify) sit of my knowledg of examination arstated. death (Item 23a)	Time of Injury M Arm, street, fa e, death occur and/or investigs (Type, Print)	28c. Injury Work 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	at ? (es 2 \sum No e, date and plainion, death or number	Death (Che g Home 28d. [Che che che che che che che che che che c	autopsy performed' Yes 2 2 ack only one) 5 Residence Describe how in cocation (Street inty or Town, St. use to the cause the time, date a	death? No 1 Yes 6 Other (Specially occurred and Number or Rate) and place, and due Date signed (Monitoria)	s 2 No ocify) ural Route Number, s stated. e to the cause(s)

2:50 а.ш.

SEPTEMBER 10, 2006

ANGELICA NEWMAN

			1. Decedent's Name (First, Middle, Last)					2. Date of Dea			3. Time of Death
П	Physici		Angelica E.	Newman				Septemb	e- 10	2006	2:50 AM
	/Medi Examir		4a. Facility Name (If not institution, give s		4b. (City, Town, o	Location of Death			nty of Death	
		•	Stella Maris H	ospice		Tim	meino		3	outim	Lore
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	ist birthday) If U	nder 1 Year		8. Date of Birt (Month, Da	h		lace (State or Foreign
	Director		219-58-5379	M 200 54	Yrs.	ths Days	Hours Min.		1, 1952	Mai	yland
	D .		Usual Residence of Decedent 10a. State 10b. County	10- 07-	T						
	anyla shov	5		Toc. City,	Town or Location		- 1			1	0d. Inside City Limits 1 Yes 2 □ No
	8 - 6 M	octo	Maryland Cecil		Port	Depo	sit				
	vith ti	Director	10e. Street and Number		10f	. Zip Code	- 1 1		10g. Citizen		itry?
	s 23s	by Funerai		Tome Hwy		2190	•			SA	
	er de	une		Was Decedent Ever in U.S Armed Forces?		ecedent of H specify Cuba	ispanic Origin? (Sp In, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. F	lace - Americ Ilack, White,	
36	rs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ₹ No If Yes, Give Year or Dates:	1□ Ye	s 2 No	Specify:		Spe	cify: Wh	صرسلوس
5-003	be filed within 72 hours after death with the Maryland nat Hygiene. ad other than "naturel", or items 23a or 28a-f show event, the Medical Exaculty at must must be notified at		15. Decedent's Educ		16a. Decedent's	Usual Occup	ation			Business/Inc	
15	nin 72	Completed	(Specify only highest grade	completed)	(Give kınd o	f work done o T use retired	during most of work	ing		000110001110	203119
2121	with iene	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	We	litres	\$		Res.	taura	n+
	Hygid other	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,	Maiden Sum	ame)	-
Maryland	should be nd Mental marked o	To B	Walter L.	Ross			Edi	na Cu	rell		
3	shound M	-	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailing Add	ress (Street	Ed and Number or Run	al Route Numbe	r, City or Tov	vn, State, Zip	Code)
	nd 2 alth a 27 is		Tray Newman	Husband							
ē,	s 1 a f Hea item othe		20a. Method of Disposition	20b. Pla	ace of Disposition metery, crematory	(Name of	(a)	Date	20c. Locatio	n - City or To	MD21904 wn, State
Ë	Page ent o nt: ff ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ② Donation 5 ☐ Other (Specify)				try Septemb	e: 10,2000	Ha	חסיברו	MD
altimore,	mit.		21. Signature of Juneral Service License		22. Nam	e and Addres	ss of Facility	tone Gi	Ctc Re	250401	
ä	permit. Pages 1 and 2 should be Department of Health and Menta Importent: if Item 27 is marked eny injury or other traumatic evonce.		130	-	7522	Con	relley Do	ان کو میں	DHO	Dones I	MD 21076
			23a. Part1. Enter the disease, or complic	ations that caused the death.	Do not enter the	mode of dyin	g, such as cardiac	or respiratory ar	rest,	003	Approximate
	Physician		shock, or heart failure. List only one Immediate Cause (Final								Interval Between Onset and Death
f	/Medical		disease or condition resulting in death)	Due to (or as a consequent	ence of):						
П	Examiner	i		D00 10 (01 23 2 001130qui	5110 0 01).						
		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	ence of):						
0	uted	E I	cause. Enter Underlying Cause (Disease or injury that initiated events								
ر آ	exec n an ial-tr	Examiner	resulting in death) Last	Due to (or as a conseque	ence of):						
9/	s be sicia e bur		d.								
Box 68760,	aath certificate be executed ettending physician and for use as the burial-transit	an/Medicai									
ŏ	h cer endin	5	IF FEMALE: 23b. Was decedent pregnant 23	ic. If yes, outcome of pregnan					23d. I	Date of delive	ry
	deat	icla	in the past 12 months? 1 ☐ Yes 2 🛣 No	1 Live birth 2 Fetal of 4 Pregnant at time of dea		ic pregnancy (specify)			1	Month	Day Year
о. О	The law requires that the de ate has been signed by the e bage 2 should be detached f	Physic	9 Unknown	9□ Unknown				-			
	ss the	by F	Part II. Other significant conditions cont	ributing to death but not resul	ting in the underlyi	ng cause give	en in Part I.	23e. Did to	bacco use co	ntribute to th	e cause of death?
Ë	w require been signatured should b							1 🗆 Y	es 2□No	3 Prob	ably 4X Unknown
000	awre is be	Plet						24a. Was	an 24	b. Were autor	osy findings available appletion of cause of
ž	The lay te has	Completed					, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	autop perfor	med?	prior to condeath? 1 Yes	
g		0	25. Was case referred to medical				26. Place of Death			1 1 1 1 1 1 1 1 1	2 NO
<u> </u>	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 🗶 No	ospital: 1 Inpatient 2 E	R/Outpatient 3	DOA Oth	ac .		1770	Other (Specify	HOSPICE
Division of Vital Records,	<u>a</u> = a		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injun Worl		28d. Describe h			, 1001101
Ö	Attending For death. ector: After by the funer	atio	1 Natural 5 Pending 2 Accident investigation	(Monal, Day 1 da)	Injury M		Yes 2 □ No				
<u>S</u>	i or Attend efter death Director:	12	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, street, fac	ctory, office		28f. Location (S City or Tow	treet and Nu	mber or Rura	Route Number,
ō	Hospital or 24 hours efte Funeral Dir tely filled in	Certification:		building, etc. (opecny)				Oily or TON	n, State)		
	To the Hospital within 24 hours e To the Funeral Completely filled		29a. Certifier 1 Certifying Physi (Check only Medical Examin	cian: To the best of my know	ledge, death occur	red at the tin	ne, date and place.	and due to the d	ause(s) and	manner as st	ated.
	he H in 24 he F	Medical	one)	er: On the basis of examination and manner stated.	on and/or investiga	tion, in my of	oinion, death occurr	ed at the time, o	ate and plac	e, and due to	the cause(s)
	To the To the Complet	Σ	29b. Signature and title of certifier			29c. License	number		29d. Date sign	ned (Month, I	Day, Year)
}	540		/ / -	-		174	3721		91	11/06	
	3		30. Name and address of person who con	npleted cause of death (Item :	23a) (Type, Print)						
_			DR. TARIQ MAHMOOD	2300 DULANE	Y VALLEY	RD.	TIMONIUM,	MD 210	93		
	Sta		31. Date filed (Month, Day, Year)	82. Registrar's Signatu	ICA						
	Registr	ar	SEP 1 3 2006	Street It	Sparke						
DH	MH 17 Rev 1/2	001			1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 2006

29045

			For State Registrar	State of Marylan	d / Depa <i>Cei</i>	artmer <i>tificat</i>	t of H e of L	ealth a Death	ind Me	ental Hyg F	giene 2	006	29047
			Decedent's Name (First, Middle, Last)						2. Date of Dea Month	Day	Year	3. Time of Death
	Physicia /Medic		Paul Adam	Ott Jr.						Septemb	er 1		6:30 A M
	Examin		4a. Facility Name (If not institution, give					Location o	f Death			unty of Death	dal
			Mariner Health of 5. Social Security Number 6. Se		last hirthday)			urnie	24 Hrs.	8. Dale of Birtl		ne Arun	lace (State or Foreign
	Funeral Director			XM 2□F	86 Yrs.	Months		Hours	Min.	Month, Day June 27	1920) Cour	PA
			Usual Residence of Decedent										
	nylan show	_	10a. State 10b. County		y, Town or Lo			1				1	0d. Inside City LimiIs 1 ☐ Yes 2√ No
	Ba-f o	Directo	Maryland Anne Aru	ndel			Pasad	jena			10a Citizan	of What Cour	
	with t	DIC	750 215th Street			10f. Zij	Code	21122	<u> </u>		rog. Citizen	USA	nty:
	ne 23	Funeral	11. Marital Status	12. Was Decedent Ever in U	S. 13.	Was Dece	dent of H	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	. 14.	Race - Americ	
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiens, and Mental Hygiens, is marked other than "natural," or items 23s or 28s-f show aumatic event, it a Medical Examination must be notified at	by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give		lfYes,spe 1 ⊡ Yes		n, Mexican Specify:	i, Puerto F	tican, etc.)		Black, White, ecify: Whi	
Maryland 21215-0036	hour turai		15. Decedeni's Edi	Year or Dates:	16a. Dece	dent's Usu	al Occup	ation			16b. Kind	of Business/In-	dustry
င်	n na	Completed	(Specify only highest grad	le completed)	(Give	kind of wo	ork done o	turing most	t of workin	ig .			,
212	d with giene	ΕO	Elementary/Secondary (0-12)	College (1-4or 5+)		Iron	Work	er			Stee	1 Indu	stry
힏	al Hygi d other	Bec	17. Father's Name (First, Middle, Last)							(First, Middle,		mame)	
<u>X</u>	should to	7	Paul A. Ott	Sr.	T			Moll		Schul			
Mar	12 sh and riem raum		19a. Informant's Name/Relationship (7	_{урө, Print)} (niece)		•				adena,			Code)
e,	1 and 1 Health em 27		Doris Keller 20a. Method of Disposition	20b. F	lace of Dispo	sition (Na	me of			-		ion - City or To	own, State
ğ	Pages nent of int: if its iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	emetery, crei ched : He	matory or	other plac		Sept. 20		Raltin	more M	laryland
altimore,	permit. Pages 1 and 2 should Department of Health and Men Important: if Item 27 ie marke any injury or other traumatic once.		21. Signal are of Funeral Service Licen							the second second			me, P.A.
Ba	Dep imp gng		1 And	1 100						d, Pasa			
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the devi the cause on each line.	h. Do not en	ter the mo	de of dryin	g, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. My or Act	10,0	n	111	124	nei	204			11+2
8760,	rate be executed by solvesticien and the burial-transit and	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that iniliated events resulting in death) Last	b. A D to or as a consequence. Due to (or as a consequence)	uence of):	015			771	110	L123	eun	2041
9 X	death certific ettending pi	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna	ancy						23d	l. Date of delive	erv
O. Box	The law requires that the death certific sie has been signed by the ettending p age 2 should be detached for use as	by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown		∃Ectopic p ∃ Other (s				(100)		Month	Day Year
<u> </u>	signed by	y Ph	Part II. Other significant conditions co	nIributing to death but not res	ulling in the u	nderlying	cause giv	en in Part J.		23e. Did to	obacco use	contribute to t	he cause of death?
Sp	quires on sign	od b								101	Yes 2□N	lo 3 ☐ Prot	pably 4 Tunknown
ပ္သ	aw requir is been si 2 should	plet								24a. Was	an 2	4b. Were auto	ppsy findings available impletion of cause of
Ĕ	The I	Completed								perfo	rmed?	death?	
<u>ta</u>	cien: ertifica	Be	25. Was case referred to medical examiner?						of Death	(Check only o	пе)		
<u></u>	hysio this c	၉	1 ☐ Yes 2 No		ER/Outpatie			4 EXINU		ne 5 ☐ Resid			(y)
2	Jing F	lon:	27. Manner of Dealh 1-⊠Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	м	28c. Injur Wor	yaı k? Yes 2		8d. Describe l	now injury o	ccurred	
Division of Vital Records,	Attending Physicien: Ir death. ector: After this certific by the funeral director.	Certification:	2 ☐ Acciden investigation 3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h	ome, farm, st			103 2				lumber or Rura	al Route Number,
<u>S</u>	after after i Dire	Sert	4 Homicide	building, etc. (Special	(y)					City or To	wn, State)		
	To the Hospital or Attending Physicien: The lawithin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical (ysician: To the best of my kno iner: On the basis of examina and manner stated.									
	To the within 2 To the complet	Me	29b. Signature and title of certifier	and marries dialog.		25	c. Licens	e number				igned (Month,	
	r> = 0		> Mu Shu	~		1)2.	78	38	1	1101	17731	2000
	n		30. Name and address of person who	completed cause of death (Iter	п 23а) (Туре				4				21090
			JUINI SITALIF	ns M.O.	518	CAT	70	MAR	יו פר	an.	1611	NIDIT	(07, 17)
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	oged.	-						-

Description of Death Application State (Pist Midgle Land) Privation Priva				For State Registrar	State of Maryland	/ Department of Certificate			2006	29048
South Section Property Prop	CE,		5			1	/	2. Date of Death		3. Time of Death
## Annex Cliss Annex France The Control							V 1	09 0	1 06	
Social Society Social Society Social Society Social Society Social Social Society Society Social Society Social Society Social Society Society Social Society Social Society Social Society Social Society Society S		Examin	er	1	10 0 0 1	4b. City, To			Λ	A 1 1
Use The state and Number 100. Colors 100	382	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	Months [ear If Under 24 Hrs.	8. Date of Birth	9. Birth	iplace (State or Foreign intry)
Secondary (Critical Special Part Control	×1,			775-19-5006	860	Yrs.		June 18,1	920 N	leatera
Secondary (Critical Special Part Control		tryland show	les .	10a. State 10b. County	10c. City,	Town or Location				
Secondary (Critical Special Part Control		the Ma	ecto		runde			10g (Citizen of What Cou	
Secondary (Critical Special Part Control		h with			Lane				USA	,
Secondary (Critical Special Part Control		teme teme	uner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	. 13. Was Deceden If Yes, specify	t of Hispanic Origin? (S Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)		
Secondary (Critical Special Part Control	36	urs afte	by F		1 XYes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2	No Specify:		Specify: W	hite
17. Father's Name (First, Middle, Mash) 18. Mother's Name (First, Mi	2-0	na na	eted	15. Decedent's Edu (Specify only highest grade	cation	16a. Decedent's Usual C	tone during most of wor	tking 16b.	Kind of Business/l	ndustry
17. Father's Name (First, Middle, Mash) 18. Mother's Name (First, Mi	121	within ene. than	ompi	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use	retired)		hotog	raphy
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23a. Part I. Enfort the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician / Medical Examiner Physician / Medical Examiner	Bai	Departing Import		21. Signature of Funeral Service License	3 8	22. Name and	Address of Ficility	rationy G. G	Regist	of second
Physician / Medical Examiner Physician / Medical Examiner		H		23a. Part 1. Enter the disease, or compliant shock or heart failure. List only or	cations that caused the death.				t as acver in	Approximate
Socientially list conditions, any, leading to immediate cause. Enter Underlying a cause. Enter Underlying that inhitiated events in the past 12 months? FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 1 ves 2 No 3 Probably 4 1 1 ves 2 No 3 Probably 4 1 1 ves 2 No 3 Probably 4 1 ves 2 No 5	12			Immediate Cause (Final disease or condition	Preu	monia			mamma tria	Onset and Death
The standard of the medical cause. Enter Underlying Cause (Disease or injury tresulting in death) Last To any iseason of the property of the past 12 months? The past 12 months	7			resulting in death)	Due to (or as a conseque.	ence of):				ulling-
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Females Color Co	H	ecuted and -transi	kami	Cause (Disease or injury that initiated events		ince of:				
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25. Was case referred to medical examiner? 1 Yes 2 No	Вох	ath ce ttendir or use	lan/h	23b. Was decedent pregnant	1 Live birth 2 Fetal d	leath 3 Ectopic preg				
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25. Was case referred to medical examiner? 1 Yes 2 No	Rec	he law e has t age 2 s	ompi					autopsy performed?	prior to o death?	ompletion of cause of
State of the state	ita		a				26. Place of Dea		10 1 Yes	2 No
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29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)		Hos 124 hc	dica	(Check only 2 Medical Exami	ner: On the basis of examinatio	nedge, death occurred at on and/or investigation, in	my opinion, death occu	rred at the time, date a	(s) and manner as ind place, and due	stated, to the cause(s)
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)		To th withir To th comp		29b. Signature and title of certrier	1 2000	A 29c. L				
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10+1 Michael J. Law TAM 44- DEFENSE Harway ANNA DOWN MOZIY		10+1		39. Name and address of person white	Impleted cruse of death (Item 2	23a) (Type, Print)	DEFENS	EMGHWA	4 ANNAG	Doug Moziya,
State 31. Date filed (Month, Day, Year) 32. Degistrar's Signature Registrar SFP 1 3 2006						le Acade				

Usual Residence of Decedent 10a. State	ABER 11 2006 7:07 A M 4c. County of Death BALTIMORE Birth Day, Year) 1943 9. Birthplace (State or Foreign Country) 10d. Inside City Limits 1 □ Yes 2 □ No
STEVEN STEVEN STEVEN STEVEN STEVEN STEVEN STEVEN	ABER 11 2006 7:07 A M 4c. County of Death BALTIMORE Birth Day, Year) /1943 9. Birthplace (State or Foreign Country) MD 10d. Inside City Limits 1 □ Yes 2\□ No
HOSPICE OF BALTIMORE GILCHRIST CTR. Funeral Director S. Social Security Number 6. Sex 219-44-9339 1 M 2 F 6. Sex 3 Months 100. City, Town or Location FINKSBURG 101. Zip Code 102. State 103. State 104. Zip Code 105. Street and Number 106. Street and Number 107/31 108. Street and Number 109. Street and Number or Rural Route No. (Specify only highest grade completed) 17. Father's Name (First, Middle, Last) KURT 199. Informant's Name/Relationship (Type, Print) 199. Mailing Address (Street and Number or Rural Route No. 1711 ANTLER LANE - FINKSBURG 1711 ANTLER LANE - FINKSBURG 180. Mother's Name of Place of Disposition (Name of Name o	BIRTH Day, Year) /1943 9. Birthplace (State or Foreign Country) MD 10d. Inside City Limits 1 □ Yes 2\□ No 10g. Citizen of What Country?
Director Direct	Day, Year) /1943 Country) MD 10d. Inside City Limits 1 □ Yes 2 □ No 10g. Citizen of What Country?
Usual Residence of Decedent 10a. State 10b. County MD CARROLL FINKSBURG 10c. City, Town or Location FINKSBURG 10d. Zip Code 1711 ANTLER LANE 11. Marital Status 12. Mas Decedent tever in U.S. 13. Mas Decedent of Hispacito Origin? (Specify Yes of If Yes, Specify Cuban, Mexican, Puerto Rican, etc. 11. Marital Status 12. Mas Decedent Status 13. Mas Decedent of Hispacitor 13. Mas Decedent of Hispacitor 14. Mari	10d. Inside City Limits 1 ☐ Yes 2 ☐ No 10g. Citizen of Whaf Country?
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No. 1 September 2012 Augustion Ship (Type, Print) No. 2 September	SOCIAL SECURITY dle, Maiden Sumame)
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ANSHE EMUNAH 1 Donation 5 Other (Specify) A TT7 CHAIM 1 DONATION 5 Other (Specify)	20c. Location - City or Town, State
	BALTIMORE, MD
m seesa locality	INSON & BROS., INC.
23a. Part1. Enter the disease, or <i>complications</i> that caused the death. Do not enter the mode of dying, such as cardiac or respirato	v arrest. Approximate
shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition MCANOMA	Interval Between Onset and Death
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dicate be exprised that the physicien of	
SOCOLOGO OCT Second Secon	23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	id fobacco use confribute to the cause of death?
Sport is sport in the sport in	☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown
	prior to completion of cause of death?
O E E T 27 Magner of Death	esidence 6 DOther (Specify) NOSPCEQ
O to	<u> </u>
27. Manner of Death 1	n (Street and Number or Rural Route Number, Town, State)
27. Manner of Death Natural Suicide Accident Suicide Suic	ne cause(s) and manner as stated. se, date and place, and due to the cause(s)
29b. Signature and title of certifier	
D58303	29d. Date signed (Month, Day, Year)
at Date Classification of the Control of the Contro	
State Registrar SFP 1 3 2006 32. Pogistrar's Signature	Septem Ser 11 2006 Ramno no 21204

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Aug Herbert Richardson 31 2006 10:43 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner The Pines Genesis HealthCare -Easton Talbot 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours Min 1 X M 2 □ F Yrs Director 83 213-22-4866 Jan 10. Usual Residence of Decedent with the Maryland 10a State 10c, City, Town or Location 10b Counts 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director MD Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 610 Dutchmans Lane 21601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: black Completed by 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education unk 16b. Kind of Business/Industry unk (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame) unk Be permit. Pages 1 and 2 sh.
Department of Health and I
Important: if Item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pines at Genesis 610 Dutchmans Lane Easton, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 □Donation 5 NOther (Specify) in state 21. Signature of Funeral Sprvice Licensee Wades State MAGUSMY Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Pant. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician ulans /Medical Due to for as a cons Examiner Sequentially list conditions, if any, loading 1, immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transli Renoscierosis and Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy or in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death Check onl. one Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 Other: Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient this 3 DOA 27. Manner of Death 1 Natural 2 Accident 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of After Certification: Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical (Check only one) Medi 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person completed cause if death (Item 23a) (Type, Print) 610 DUTCHMANS 31. Date filed (Morith, Day, Year) gistrar's Signature 32 Registrar

Herbert Richardson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Ragistrar Certificate of Death Reg. No. 2 1 6 2. Date of Death 1. Decedent's Name (First, Middle, Last) September Date 2008 ar 2350 Robert Roemer 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Bel Air Upper Chesapeake Medical Center If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1⋤M 2□F Months Days 213-09-9250 Yrs Mary Tand May 4, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Bel Air Harford 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21014 U.S.A. 208 Highland Road 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) sheet metal worker 8 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Carrie Skuhr Max Roemer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 208 Highland Road, Bel Air, Md. 21014 Geraldine Roemer/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Highview Mem. Gdns. 9/11/2006 Fallston, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. 21. Signature of Funeral Service Licensee 610 W. MacPhail Road, Bel Air, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only are cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BILATERAL PNEUMONIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events Due to (or as a consequence of): 23d. Date of delivery

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

Funeral

Director

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permit. Pages 1 and 2 should be fit.
Department of Health and Mental Hy
Importent: if Item 27 is marked othe
eny injury or other treumails.

the Medical Examiner Hust be notified at

Director

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Completed

Examine the attending physicien and the for use as the burial-transit signed by the all

MOOHUT

P.O. Box 68760

Records,

Vital

Division of

Attending

Physician/Medical þ Completed filled in by the funeral director, Be P Certification: death. To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A

resulting in death) Last IF FEMALE 23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No

9 Unknown

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

Month

23e. Did tobacco use contribute to the cause of death?

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an

3 Probably 1 ☐ Yes 2 ☐ No

autopsy performed? 26. Place of Death | Check only one

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes

25. Was case referred to medical examiner? 2 1 🗌 Yes 27. Manner of Death 1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier

Medical

State

4 | Homicide

5 Pending investigation 6 Could not be determined

3

1 Department 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? М

1 Yes 2 No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifie

29c. License number 26191 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Name and address of person who completed cause of death (Item 23a) (Type, Print) BELDIN ROAD, SWITE 10, FAUSTON, MO 21047 SIRITHARA

Hospital:

ANUSHA 31. Date filed (Month, Day, Year) 2006

32 Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 2006 29052 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 13:018 08 2005 Natalie M Roskott /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City Good Samaritan Hospital Baltimore If Under 1 Year
Months Days If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Min. Hours Yrs Director 215 22 1549 June 30 1927 Baltimore City, MD Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or Itema 23a or 28a-f show traumatic event, it a Madical Exertinar must be notified at 1 ☐ Yes 2 ☐ No Director Baltimore City Maryland Baltimore the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5621 Greenhill Avenue 21,206 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married ☐Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates: Specify: 3 XWidowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 WΑ Secretary State of Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nathaniel E Meakin Helene Schaller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is it sny injury or other traum once. Joyce Contrino 2116 Turky Point Road Baltimore, Md. 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery September 13 2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Lassahn Funeral Home Inc. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, series Cause (Final Cause Approximate Interval Between Onset and Death Immediate Cause (Final Left Malanic and intraventricular hemorrhage. **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Coagulo PATA O
Due to (of as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated apport.) Examine or Attending Physician: The law requires that the death certificate be executed Fibrilation ATVIAL that initiated events resulting in death) Last Due to (or as a consequence of): O. Box 68760, Hypertension Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown Division of Vital Records, P. Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed' 2**X** No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 1 Npatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Hospital Curtifying Physician: To the best of my knowledge, death opened at the time, date and place, and due to the caucate) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 25a Cartifier (Chack only one) and manner stated. To the 29b. Signature and title of continer 29c. License number 29d. Date signed (Month, Day, Year) BSagtian 9/08/2006 30 Name and address of person who completed cause of death (Item 23a) (Type, Print))9a 20 hman 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State SEP 1 3 2006 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Granville T. Redding Certificate of Death Reg. No Decedent's Name (First, Middle,Last) 2 Date of Death Physician/ Month Day September 4, 2006 2052 hrs Granville T. Redding Medical Examiner 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Annapolis Anne Arundel Anne Arundel County Medical Center If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5 Social Security Number **Funeral** Foreian Davs Hours Months Director 194 9CountryMaryland March 24 214-48-2225 1X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 X Yes 2 No Annapolis Maryland Anne Arundel 28a-f show Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21409 USA "natural", or items 23a or 457 Broadneck Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces 1 Never Married Yes 2 X No Specify: Black 4 X Divorced If Yes, Give Year 1 Yes 2 No specify: 3 Widowed hours after Pages I and 2 should be filed within 72 hours after nent of Health and Montal Hygiens and I flee and and and it it em 27 is marked other than "natural", or other traumatic event, the Medical Examiner. à 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 h Department of Health and Montal Hygiene Important: If item 27 is marked other than "injury or other traumatic event, the Medical E. Elementary/Secondary (0-12) Self Employed Tree Removal Service 11th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Doris E. Sedgwick Granville T. Redding II Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Broadneck Rd. Annapolis, Md. 21409 Doris Mathews (Mother) 20b, Place of Disposition (Name of cemetery, M tcrematery or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 9-11-06 Arnold, Md. Church Cemetery 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22.Name and Address of Facility Wm. Reese & Sons Mortuary, P.A. Part I. Epfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21401 Approximate Interval **Physician** Retween Onset and /Medical Right hemothorax Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Subclavian and lung injuries during line replacement Sequentially list conditions, Due to (or as a consequence of) Examiner it any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical X UNPENDED AMENDED/23a-b, PII,27,28a-f,perME,g860, 10/26/06 TT physician a Box 68760. 23c. If yes, outcome of pregnancy 23d Date of delivery IF FEMALE 23b. Was decedent pregnant in the Year Live birth 3 Ectopic pregnancy Day Month Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. þ 1 Yes 2 No 3 Probably 4 V Unknown Chronic drug use Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has death? performed ✓ Yes 2 No 1 🗸 Yes 2 No 26. Place of Death (Check only one) After this certifi 25. Was case referred to medical Hospital or Attending Physician: Be Other Nursing Home 5 Residence 6 Other examiner? 1 V Yes 28d Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Natural 1 Yes 2 y No Pending Director: d in by the f 9/4/2006 e Funeral Director: unknown during therapeutic procedure 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 040 Bay Ridge Road Annapolis, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be or Town, Sta Annapolis. determined emergency room Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the the and manner stated. 29d Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie September 7, 2006 O.C.M.E a 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Patricia Aronica-Pollak MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year)

ORIGINAL

State

Registrar

2006

State of Maryland / Department of Health and Mental Hygiene 006 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) -30 PM 2006 **Physician** MSC elen ptember /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner imore Balti more zaheth Center Cal NSING Hours Min. 8. Date of Birth 01/21/1909 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Mary Tand 1 M 2 XF 214-38-3134 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. fnside City Limits 10a. State 10b. County 28a-f show other traumatic event, the Madical Examinar haust be notified at 1 Yes 2 No Maryland Baltimore Funeral Director Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a or 2 any injury or other traumatic event, the Mydical Examinar page. 5729 Mineral Avenue 21227 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Mo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NOT use retired) 16b. Kind of Business/fndustry 15. Decedent's Education (Specify only highest grade completed) Colfege (1-4or 5+) Elementary/Secondary (0-12) Public School Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Bornscheuer Margaret Dunn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice B. Richter/Daughter 7808 Kawshek Path, Hanover, Maryland 21076 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Oaklawn Cemetery 09/12/2006 Baltimore, Maryland □Donation 5 □ Other (Specify) 21 Signature of Funeral Service License 22. Name and Address of Facility Hubbard Funeral Home, 4107 Wilkens Avenue, Baltimore, 21229 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. fmmediate Cause (Final disease or condition resulting in death) **Physician** noxemia day /Medical Due to (or asia consequence of) Examiner 0/01/1 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-trapsit PONS and Due to (or as a consequence of) physician Box 68760 Physician/Medical use as IF FEMALE: 23c. ff yes, outcome of pregnancy
1 Live birth 2 Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown ğ Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown signed by Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, pg 0 1 ☐ Yes 2 ☐ No 3 Probably page 2 should 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? NSION certificate 1 ☐ Yes 2 No 1 Yes 2 No 17. To the Hospital or Attending Physician: in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 2 No 1 ☐ Yes 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 2 Accident 5 Pending М 1 ☐Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide completely filled Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month. Day. Year) 29b. Signature and title of certifier Name and address of person who completed au e of death (Item 23a) (Type, Print) timere enson 31. Date filed (Month 32 Registrar's Signature Day, Year) State Registrar 3 2006

State of Maryland / Department of Health and Mental Hygiene 2006 29055 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JOSEPH V. RIVERA September 8 Zaib 10 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner LEVINDALE BALTIMORE CITY Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1X1M 2□ F Director 069-12-7337 81 PUERTO RICO 11/2/1924 Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Yes 2 No Director CARROLL WESTMINSTER 10e: Street and Number 10f. Zip Code 10g. Citizen of What Country? 1000 WELLER CIRCLE, APT. 212 21158 USA items 23a 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 72 hours after 1 Tayes 2 □ No
If Yes, Give
Year or Dates: WWII 1 Never Married 27 Married Baltimore, Maryland 21215-0036 ö 1X Yes 2□ No Specify: PUERTO RICO Specify: WHITE 2 3 Widowed 4 Divorced 'neturel', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 7 Hygiene. other than *n Elementary/Secondary (0-12) Coflege (1-4or 5+) 12 CARTOGROPHER GOVERNMENT s 1 and 2 should be filed of Health and Mental Hygi Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ANGELO RIVERA RAMONA OROPESA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21158 1000 WELLER CIRCLE, APT. 212, WESTMINSTER, MD ROSE H. RIVERA - WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
importent: if ites
any injury or ott 1 🔀 Burial 2 □ Cremation 3 □ Removal from State MEADOW BRANCH CEM. 9/11/06 WESTMINSTER, MD 4 ☐ Donation 5 ☐ Other (Specify) Signal e of Funeral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final Krotic Cardiouscular **Physician** Atherosc disease or condition resulting in death) /Medical Examiner Hypertension Sequentially fist conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physicien Box 68760 certificate be Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No P.O. 9 Unknown ۾ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA SHI 27. Manner of Death 1 Natural 2 Accident 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred After Division Hospital or Attanding 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a: To the Funeral D ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Ca (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) ertheiner np 2434 32. Registrar's Signature Grande State 3 Jan September Registrar

			For State Registrar	State of M	arylar	nd / Depa	artmer	nt of H te of L	ealth an Death		F	leg. No.		29056
	Physici	an ·	1. Decedent's Name (First, Middle, L	ast)						2.	Date of Dea Month	ith Day	Year	3. Time of Death
	/Medic	al	Tessie			Siegfr	7	Town	Location of D		eptemb		2, 2006 County of Dea	
	Examin	er	4a. Facility Name (If not institution, g Suburban Hospi		,			thesd		bain				
	Funeral			Sex 7. A	ge (In yrs.	last birthday)		r 1 Year	If Under 24	Hrs. 8. Min.	Date of Birtl (Month, Day		ontgome 9. Bir	thplace (State or Foreign ountry)
	Director		052-12-5814	1□M 2XF	85	Yrs.	Months	Days	Hours	A A	ug. 6,	19:	21 New	York
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits
	Mary -faho	tor	Maryland Montgo	m <i>e r w</i>	C + 1	ver Sp	ring							1 XYes 2 No
	h the	Director	10e. Street and Number	ист у	تيرن ا	ver bp		p Code				10g. Citi:	zen of What C	ountry?
	23a c	raiD	2921 N. Leisure	World Blvd	•		20	908			c	U.S	.A.	
	er dee	Funeral	11. Marital Status	12. Was Decedent Armed Forces	?		Was Dece If Yes, spe	dent of Hi	spanic Origin' n, Mexican, P	? (Specifi uerto Ric	y Yes or No- an, etc.)		 14. Race - Am Black, Whi 	
36	irs aft	by F	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕅 If Yes, Give Year or Dates:	No		1 ☐ Yes	2 ∏ No	Specify:				Specify:	White
21215-0036	within 72 hours after deeth with the Maryland ene. than "natural", or items 23e or 28e-f ahow the Medical Evantiral must be notified at	ted	15. Decedent's	Education		16a. Dece	dent's Usu	al Occupa	tion			16b. Kir	nd of Business	
218	ithin 7	Completed	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or	5+)				uring most of	working				
7	led will her th	Cor	12	-41		Но	memal	cer	10 Markada	Name (F	Times Adiabatic		wn Home	
and	ntal Hed ot	Be	17. Father's Name (First, Middle, La.	st)					18. Mother's				Sumame)	
Maryland	should nd Me mark matic	ဥ	Julius Kaplan 19a. Informant's Name/Relationship	(Type, Print)		19b. Mailii	ng Addres	s (Street a		`	known) loute Numbe		r Town, State,	Žip Code)
Ž	nd 2.		Ronald Siegfrie	d (Son)			_		t., Br			-		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Heelth and Mental Hygiane. Important: if item 27 is marked other than "natural; or items 23a or 28a-f ahow apprintury or other traumatic event, the Medical Examinat must be notified at ancie.		20a. Method of Disposition 1 Burial 2 □ Cremation 3	□ Domoval from State	20b. F	Place of Dispo cemetery, crei	sition (Na matory or	me of other place	9)	Date	•	20c. Lo	cation - City or	Town, State
Ē	Page ment ant: th		4 Donation 5 Other (Spec		'	th Mos				/3/06	5	Pine	lawn,	NY
3alt	Depertiment in portion		21. Sign ture of Funeral Service Lic	опзее		22	Sheri	nd Addres nan F	s of Facility uneral	Hom	.e			
	40.2 e a		23a. Part1. Enter the disease, or co	molications that cause	d the deat								klyn, N	Y 11230 Approximate
	Physician /Medical Examiner		shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a. <u>Corona:</u> Due to (or as	ry Ar		iseas	se						Interval Between Onset and Death
/	ecuted and transit	Examiner	Sequentially list conditions, if any, isating to miniociate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as										
	cate be executed physician and the burial-transit	icai		d				•						
.O. Box 6	Physician: The law requires that the death certificat this certificate has been signed by the ettending phy rai director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	al death 3[Ectopic p					2	23d. Date of de Month	olivery Day Year
d' S	ires that signed b d be deta		Part II. Other significant conditions Encephalopathy	contributing to death	but not res	ulting in the u	nderlying	cause give	n in Part I.					o the cause of death?
Sor	w requir been si should	etec	Zirocpiiazopasiiy							_	24a. Was	-	T	utopsy findings available
Vital Records,	ding Physician: The lav h. After this certificete has funeral director, page 2	Completed								_	autop perfor	sy med?	prior to death?	completion of cause of
<u> </u>	siciar certif	o Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	Hospital:	iont 2 🕅	ER/Outpatier	- 2 D	Othe	26. Place of					
ō	a Phy er this		27. Manner of Death	28a. Date of Inj (Month, Date		28b. Time o		28c. Injury Work	4 1401511		I. Describe h		Other (Specy occurred	эспу)
ion	Attending r death. ector: After by the fune	atio	1 Natural 5 Pending 2 Accident investigat	on	ay rear)	Injury	м		? ∕es 2 □ No					
Division of		Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		iury - At h tc. (Speci	ome, farm, str fy)	eet, factor	y, office		28f	Location (S City or Tow			ural Route Number,
	ne Hospitei or n 24 hours affe e Funerei Dir bletely filled in I	Medical	29a. Certifier 1 → Certifying I (Check only 2 → Medical Ex-	Physician: To the best aminer: On the basis of and manner s	of examina	owledge, deat ation and/or in	h occurred vestigation	at the tim	e, date and p inion, death o	olace, and	I due to the d at the time, d	ause(s) date and	and manner a place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	/M P	14.		29	c. License					e signed (Mon	
}	/		1 Jours	of the	11.0	/,		D005	7011		5	Septe	ember 1	3, 2006
	15		30. Name an Address of per on Manish Oza, M.D		death (Iter			Geor	getown	Rd.	, Beth	nesda	a, MD 2	0814
4	Sta Registr		31. Date filed (Month, Day, Year)	2006 32. Regist	rar's Signa	ature	Soul	رع						

DHMH 17 Rev 1/2001

ORIGINAL

		ı	For State Registrar	State of Mary		artment of H rtificate of L			ene 9. No. 2006	29057
	Physici		1. Decedent's Name (First, Middle, Last) Ansel O. Summerlin					2. Date of Death		3. Time of Death 10:28P M
	/Medic Examin		4a. Facility Name (If not institution, give so Peninsula Regional	-	enter	4b. City, Town, or Salis	Location of Death		4c. County of Death	1
F	Funeral Director		579-48-4185	M 2□F	n yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov. 26	Year) Cou	place (State or Foreign intry) Cgia
Maryland 21215-0036	be filed within 72 hours after deeth with the Maryland tial Hygiene. ad other than "natural", or iteme 23a or 28a-1 ehow event, the Mudical Examinar must be notified at	Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County MD Wicomico 10e. Street and Number 116 Walston Avenue 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	2. Was Decedent Eve Armed Forces? 1Yes_ 2 No If Yes, Give Year or Dates:	16a. Deced	lisbury 10f. Zip Code 21804 Was Decedent of Hi f Yes, specify Cuba 1 Yes 20 No dent's Usual Occupa kind of work done of NOT use retired. Business	Specify: ation turing most of work Owner	ecify Yes or No- Rican, etc.)	6b. Kind of Business/N	ces ican Indian, , etc. nite ndustry
arylan	should be ind Mental marked c	ToB	Ansel Summerlin 19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailir	ng Address (Street a	Lilly W		City or Town, State, Z.	ip Code)
ໝົ	ages 1 and 2 should to to the alth and Ment it: If item 27 is marked y or other traumatics		Mitchell I. Summer 20a. Method of Disposition 1X Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State	20b. Place of Dispo cemetery, cren	sition (Name of matory or other place	9)	Date 2	ake Beach, Oc. Location - City or T centwood, N	own, State
Baltir	permit. Pages 1 Department of h Important: If ite any injury or ot		21. Signature of Fundal Service Licenser	•	22	. Name and Addres	s of Facility Ha	rman Fune	eral Servio G, Glen Bur	ce, P.A.
	death certificate be executed We attending physicien and tor use as the burial-transit	dical Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) 5	cause on each line.	onsequence of):					Approximate Interval Between Onset and Death
P.O. Box 68	death certif e attending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of p 1 Live birth 2 C 4 Pregnant at tim 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliving Month	very Day Year
Vital Records, P.	e taw requires has been sig ye 2 should be	Completed by Ph	Part II. Other significant conditions cont Lung Genee Is Chemic A	Heart C	Acute Ra Viseuse	Zenal 1	Am /		24b. Were aut	the cause of death? bably 4 Unknown opsy findings available ompletion of cause of
Division of Vital I	ing Physicien: After this certifica uneral director, p	To Be	25. Was case referred to medical examiner? 1 Yes 22 No Ho 27. Manner of eath 1 Natural 5 Pending Investigation		2 ER/Outpatien 28b. Time of Injury	ot 3 DOA Other	4 Nursing H	1 ☐ Yes 2 h (Check only one	1 Yes) nce 6 Other (Spec	
Divis	ital or Attendi rs efter death. rei Director: A ied in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (S	Specify)			City or Town,		
	To the Hospital or Att. within 24 hours efter de To the Funerei Direct completely filled in by t	fedical	(Check only 2 Medical Examin	cian: To the best of m er: On the basis of ex- and manner stated	amination and/or in	vestigation, in my op	pinion, death occur	red at the time, dat	use(s) and manner as le and place, and due	to the cause(s)
)	가 보다 등	Σ	29b. Signature and Nie of certifier	I A	1.0.	29c. License			d. Date signed (Month	
	Sta Registi		30. Name address of pers who core and a second seco	32. Registrar's	h (Item 23a) (Type,	Print) 145 E	Corr	o11 ST	, Solis	ber, MD

06-06617 Michael Schmidt

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygien

iaei Sciimid		1. For State Registrar State of Maryland / Department o Certificate o	, ,							
Physici dical Exam		1. Decedent's Name (First, Middle, Last) Michael C. Schmiot	2. Date of Death Month Day Year September 4, 2006 3. Time of Death 1115 hrs							
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death							
Funeral		Francis Scott Key Bridge 5. Social Security Number								
Director		216-04-0363 1 MM 2 F 23 YM	Months Days Hours Min. Foreign							
any		Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Loca	cation 10d. Inside City Limits							
ne Maryland or 28a-f show any fied at once	'n	MD BALTIMORE 7	UNDALK 1 Yes 2 10							
vith the Maryland s 23a or 28a-f show s n diffed at once	Director	10e Street and Number	10f. Zip Code 10g. Citizen of What Country?							
th th 23a noti			2 12 2 U. S. A. s Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black,							
r death wi or items must be	Funeral		es, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.							
s after ral", o	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	Yes 2 No specify: Specify: White							
2 hour	Completed		at's Usual Öccupation (Give kind of work done ost of working life. DO NOT use retired)							
Z IZ IS-0050 buld be filed within 7 Mental Hygiene marked other thau ic event, the Medica	m g	12th NIA	Mechanic CAR Dealership							
filed w I Hygic ed othe t, the	ပ္ပိ	17. Father's Name (First, Middle, Last) Michael R. Schmidt	18. Mother's Name (First, Middle, Maiden Surname)							
Menta Mark mark	lo Be		Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
BAILLINGTE, INID Z 1 Z 1 D-0030 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene Important: If item 77 is marked other than "natural", injury or other traumatic event, the <u>Medical Examiner</u>		Michael R. Schmidt 6904	Sollers PT RO. BALto MO 21222							
Dalumore, bermit. Pages I an Cepariment of Hea Important: If iten njury or other tra			ition (Name of cemetery, ner place) Date 20c. Location - City or Town, State							
permit. Page Department of Important: injury or other		4 Donation 5 Other Specify: BAYVILW 21. Stenature of Funeral Service Licensee	Crematory 9/6/06 BALTO MD							
Depa Impo		Vaul M. Stella	lame and Address of Facility AUL STELLA FUNERAL HOME, PA 2527 has rosed Ra BA Ito MO 21234							
hysician		23a. art I. Enter the disease, or complications that caused the death. Do not enter- failure. List only one cause on each line.	ne mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and							
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Death							
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.								
	iner	if any, leading to immediate Due to (or as a consequence of): cause Enter Underlying Cause	•							
d sit	Examiner	events resulting in death) Last Due to (or as a consequence of):								
ind Vical Records, F.O. BOX 600 fou, Ing Physician: The law requires that the death certificate be executed. After this certificate has been signed by the attending physician and uneral director, page 2 should be detached for use as the burial - transit		d. UNPENDED AMENDED								
ate be e	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery							
e death certificate be the attending physici ed for use as the buri		23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 For a pregnant at time of death	tal death 3 Ectopic pregnancy Month Day Year							
death he atter d for u	Physician/	1 Yes 2 No 9 Unknown 9 Unknown	her (Specify)							
s that the gned by the e detache	by Pt	Part II. Other significant conditions contributing to death but not resulting in the								
quires t quires t en sign ald be c			1 Yes 2 V No 3 Probably 4 Unknown 24a Was an 124b Were autopsy findings available							
ng Physician: The law require this certificate has been simeral director, page 2 should b	Completed		autopsy prior to completion of cause of							
r: The tificate or, page		25. Was case referred to medical	1 ✓ Yes 2 No 1 ✓ Yes 2 No 26 Place of Death (Check only one)							
ysician his cer directo	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	Other							
Attending Physician: The r death. ector: After this certificate by the funeral director, page	=	27. Manner of Death 28a. Date of Injury 28b. Time of A. (Mogth, Dax Year) 2200 bro	Subject jumped from bridge							
Attend r death ector: by the	catic	2 Accident Investigation	Tes 2 V No							
Hospital or Attendii 24 hours after death. Funeral Director: A tely filled in by the fu	Certification:	3 Suicide 6 Could not be determined (Specify) River	28f. Location (Street and Number or Rural Route Number, City or Town, State) Francis Scott Key Bridge, Dundalk, MD							
Hospi 24 hou Funer		20a Cartifier	red at the time, date and place, and due to the cause(s) and manner as started.							
DIVISION To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated	ion, in my opinion, death occurred at the time, date and place, and due to the cause(s)							
	Σ	29b Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 5, 2006							
/		30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E. September 5, 2006							
Y			Street, Baltimore, MD 21201							
	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	ende o							
Regis	પાદી	SEP 1 3 2006 Region AF A	needs							

OCME 2006

		1	For State Registrar	State of	Maryland	/ Depa <i>Cer</i>	rtment of tificate	Health a of Death	and M	ental Hy	giene 0	06	290	159
	3.		Decedent's Name (First, Middle, Last)							2. Date of De Month	ath Day	Year	3. Time of	Death
	Physicia /Medic		Elon Smith						9	Septem		2006	4:45	Р М
r.	Examin	3	4a. Facility Name (If not institution, give street and number)				4b. City, Town	n, or Location	of Death		4c. County	y of Dealh		
		·	44 College Creel				Annar		O4 Hen			Aru		
	Funeral		5. Social Security Number 6. Sex 1 1 1 1	7. 4.25√2 F	. Age (In yrs. las	5 Yrs.	If Under 1 Ye Months Da		Min.	8. Date of Bir (Month, Da Aug 5	1941	Mary	place (State or ntry) Land	' Foreign
	Director	-	Usual Residence of Decedent											
	how		10a. State 10b. County		10c. City, 1							1	10d. Inside Cit	·
	Ba-fs	cto	Maryland Anne Aru	naer	A	nnap				1	10. 0111	14/11-0		
	with the	급	10e. Street and Number 44 College Creek	Terr	ace		10f. Zip Cod	401			10g. Citizen of USA	what Cour	iiu y :	
	ns 23	eral		. Was Deced	ent Ever in U.S.	13. \	Vas Decedent Yes, specify (igin? (Spe	ecify Yes or No		ce - Americ		
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23e or 28e-f show it items 21is marked other than "natural", or items 2 is marked other than "natural" or other traumatic event, the Madical Examinar must be notified as	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Force 1 Tyes 2 If Yes, Give Year or Dat	No No		fYes, specify ©			Rican, etc.)	Specia	ack, White, ify: BI	lack	
9	72 hou		15. Decedent's Educa (Specify only highest grade			16a. Deced	lent's Usual Ockind of work do	cupation	st of worki	ng	16b. Kind of E	3usiness/In	ndustry	
215	within 7 ene. than "r	Completed	Elementary/Secondary (0-12)	College (1-4	4or 5+)	life. I	DO NOT use re	tired)					_	
2	e filed wall Hygier other the		12th 17. Father's Name (First, Middle, Last)	0		Lau	ndry A			(First Middle	Commun		Launc	ıry
Maryland 21215-0036	d be fi) Be	Waverly Smith							Pinde		,		
Z	2 should be and Mental is marked o	ပ	19a. Informant's Name/Relationship (Typ								er, City or Town			01.0
	1 and 2 Health a tem 27 is		LaShawn Cager(Da	ughte	r)	44 C	ollege	Cree	k Te	rrace	Annap			2140
Baltimore,	Pages 1 and of He and: If item		20a. Method of Disposition 1 ⊞ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from Si	Beer	Blooper	sition (Name o fa py or other 1 Park	place)	9-13	-06	20c. Location Annape	•		
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licenses Lavory L. Ree	MOC	483	₩. 8	m ^{Name} Ree 21 Wes	t St.	Sons Ann	Mort apoli	uary, :	P.A. 214	01	
	9 de 4a		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that can cause on ea	used the death. ch line.	Do not ent	er the mode of	dying, such as	s cardiac o	or respiratory a	irrest,		Approximate Interval Beh Onset and I	ween
1	Physician		Immediate Cause (Final disease or condition	li	ina	Can	cec						2mm	ths
1	/Medical Examiner		resulting in death)	Due to (o	r as conseque	nce of):								
4	4.00	7	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (o	or as a conseque	nce of):								
Γ	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.											
ó	The law requires that the death certificate be executed tie has been signed by the ettending physician and bage 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (o	r as a conseque	nce of):								
8760,	cate be ohysicia the bu	Physiclan/Medical	d.											
9	ertifica ling pt e as t	Med	IF FEMALE:	a liftuage auto	ome of pregnance						934 5	and of delle		
Вох	eath certific ettending p I for use as 1	lan/	in the past 12 months?	1 Live bir	th 2 ∏ Fetal d int at time of dea	eath 3	Ectopic pregn					ate of deliv Nonth	*	Year
P.O.	t the de by the e tached	iysic	1 ☐ Yes 2 ☒No 9 ☐ Unknown	9☐ Unknov				/	. W					
	res that igned b be deta	by Pr	Part II. Other significant conditions con-	ributing to dea	ath but not result	ing in the u	nderlying caus	e given in Part	i.	23e. Did	tobacco use co	ntribute to	the cause of c	leath?
rds	w require: been sig should b	ed b								1,20	Yes 2□No	3 🗌 Pro	bably 4 □l	Unknown
Records,	ne law re has ber ge 2 sho	Completed								24a. Wa auto	psy	prior to co	opsy findings ompletion of c	available ause of
Œ.		Com								peri 1 ☐ Yes	ormed? 2 No	death? 1 ☐ Yes	2□ No	
Vital	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:				Other		h /Check on/				
of	this al di	2	1 ☐ Yes 2 No	1 🗆 1		R/Outpatie 8b. Time o	_	4 🗆 🗅	lursing Ho		how injury occi	ther (Speci urred	afy)	
	Jing Afte fune	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date o (Month	n, Day Year)	Injury	М	injury at Work? 1 ☐ Yes 2 ☐			. ,			
Division	I or Attending after death. Director: After	Certification:	3 Suicide 6 Could not be determined	28e. Place buildin	of Injury - At hom g, etc. (Specify)	ne, farm, st	reet, factory, of	fice			(Street and Num own, State)	nber or Rui	ral Route Nurr	iber,
_	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one) 1 Certifying Phys	ician: To the er: On the ba and mann	sis of examination	ledge, deal on and/or in	h occurred at to	ne time, date a my opinion, de	and place, eath occur	and due to the red at the time	e cause(s) and r	manner as e, and due	stated. to the cause(s	s)
	To the Within To the	Me	29b. Signature and title of certifier					cense number			29d. Date sign	ned (Month	n, Day, Year)	
			De Slome	Lem]	1846	0 1		Septe	mher	, 12, 2	000%
~	2		30. Name and address of person who co	mpleted cause	e of death (Item :	23a) (Type		. 11		· A.	10 1	nolan	OCUA.	211-1
	8		Donna Cham		MD I	33 1	refens	e Hu	34 5	sure	Septe 112 Anr	14/10	USPI	121401
*	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Re	egistrar's Signatu	Asea	E. S		7					

ORIGINAL

SEPTEMBER

SHEARER

CHARLES

			1 = For State Registrar	State of Ma		artment of Health and Natificate of Death		en& 0 0 6	29061				
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	JUANITA	A FAYE	SMITH	2. Date of Death Month SEPT. 1	Day Year 0, 2006	3. Time of Death 2:45 P M				
la i	Examin	200	4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or Location of Death		4c. County of Deat	h				
A		2	CARROLL HOSPI		O Data of Black	CARROI	L hplace (State or Foreign untry)						
c 1	Funeral Director		5. Social Security Number 243-22-9218 7. Age (In yrs. last birthday) 1 M 2 F 85 Yrs. 1 Under 1 Year If Under 24 Hrs. Hours Min. Nonths Days Hours Min. 4 / 16 / 1921 NOR!										
	/land		10a. State 10b. County	·		10d. Inside City Limits							
	a-f eh	ctor	MD CARROLL		WESTM	INSTER			1 ☐ Yes 2X No				
	or 28	Olre	10e. Street and Number			10f. Zip Code	10	g. Citizen of What Co	untry?				
	s 23s	rall	702 YORKMINSTE	R LANE		21158	noit. Van ar Na	USA 14. Race - Ame	rican Indian				
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Independent in the matural, or items 23a or 28a-f ehow event, the Modical Examinat must be notified at	by Funeral Director	11, Marital Status 1 □ Never Married 2 □ Married 3 Widowed 4 □ Divorced	Armed Forces? 1 Tyes 2 No lif Yes, Give Year or Dates:	0	Was Decedent of Hispanic Origin? (Si If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 🏋 No Specify:	o Rican, etc.)	Black, White	e, etc.				
5-0	72 ho natur	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give	edent's Usual Occupation e kind of work done during most of wor		6b. Kind of Business/	Industry				
121	within ene. than	mple	Elementary/Secondary (0-12)	College (1-4or 5-	ife.	DO NOT use retired)		IN NICE A COME	DINC				
	filed withi Hygiene. other then		12 17. Father's Name (First, Middle, Last)			SEAMSTRESS 18. Mother's Nan	ne (First, Middle, M	IANUFACTU aiden Sumame)	RING				
an	should be nd Mental marked o	To Be		TLEY	MITCHAM	RUSHII	E S	MITH					
Maryland	2 should and Men ie marke sumatic		19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mail	ing Address (Street and Number or Ru	ral Route Number,	City or Town, State, 2	Zip Code)				
	D ≣ Z		ERIC SMITH 20a. Method of Disposition	- SON	702 20b. Place of Disp	YORKMINSTER LAN		MINSTER, Oc. Location - City or					
Baltimore,		N	1 ☑ Burial 2 ☐ Cremation 3 ☑ R	ernoval from State	cemetery, cre	ematory or other place) 9/14	1/06	UDSON, N					
iŧi	1 5 5 5	1	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Line inse	11-4-		22. Name and Address of Facility FI							
B	Depariment once		I Yan the	STER, MD									
ķ.	· *.		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximately a such as cardiac or respiratory arrest, shock, or heart failure.										
	Physician	Immediate Cause (Final disease or condition A cute Myocardial Interction											
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):	ter Die							
***		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a	(ACY / t	riay visas	_						
10	ficate be executed physician and is the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events										
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68760,	ate be hysici the bu	edical											
9	ertific ding p		IF FEMALE:	3c. If yes, outcome of	of prognancy			201 2 1 1 1					
S. Box	law requires that the death certifics as been signed by the attending ph 2 should be detached for use as th	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 □ Live birth : 4 □ Pregnant at : 9 □ Unknown	23d. Date of del Month								
P.0	res that the de igned by the a be detached		Part II. Other significant conditions cor	tributing to death bu	it not resulting in the	underlying cause given in Part I.	23e. Did tob	tobacco use contribute to the cause of death?					
Records,	tuires n sign aid be	d by					1 ☐ Ye	s 2 No 3 P	obably 4 Unknown				
CO	aw requir s been si 2 should i	Completed					24a. Was an autopsy		utopsy findings available completion of cause of				
Re	The law	mo					perform	ed2 death?	2 No				
Vital	Physician: The lithis certificate harral director, page	Bec	25. Was case referred to medical examiner?				th (Check only one)					
of V	Physic this co	ဥ	1 Yes 2 No	lospital: 1 Inpatie				nce 6 Other (Spe	city)				
Division o	After After fune	Certification:	27. Manner of Death 1	28a. Date of Injur (Month, Day	y 28b. Time Year) Injury	of 28c Injury at Work? M 1 Yes 2 No	28d. Describe how injury occurred						
Divis	al or Att s after de il Direct	Sertific	3 Suicide 6 Could not be 4 Homicide determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number City or Town, State)						
	To the Hospital or Attending within 24 hours after death. To the Funaral Director: Afte completely filled in by the fune	Medical (examination and/or i	ath occurred at the time, date and place nvestigation, in my opinion, death occu							
	To th withir To th comp	Me	29b. Signature and title of certifier	Shil		29c. License number D0064789		d. Date signed (Mont /11/06	ћ, Day, Year)				
	2		30. Name and address of person who co	mpleted cause of de	eath (Item 23a) (Type	e, Print)		21157					
				M.D.,	224 WASH	INGTON HTS. MED	CTR.		TER, MD				
100	Sta Regist		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	3.0							
	riegist	reit	SEP 1 3 2006	Belying.	15° ASTERIE								

			i icusc	State of Maryl					-		_	
			1 - For Stata Registrar	State of Mary		ertifica			wientai ny	gierie 2	2006	29062
			Decedent's Name (First, Middle, L.	ast)				<i></i>	2. Date of De			3. Time of Death
	Physic /Medi		Frank Burton	Spangler					Month	Oay	20000	11:010 M
	Exami		4a. Facility Name (If not institution, gi	ve street and number)	1	4b. CH	y, Town, or	r Lecation of Deat	h		unty of Death	
				are Hospit	tel	1	10se	age			17mo	(e)
	Funeral			4 CI M 2 CI E	yrs. last birthda Yrs.	Month	ler 1 Year s Days	If Under 24 Hrs Hours Min.	8. Date of Bi	rth ay 1927	9. Birthp	lace (State or Foreign try) Virgini
	Director		234-36-9625 Usual Residence of Decedent	** 79	9		<u> </u>		02/10	71321	wes	c virgini
	nyland how	١.	10a. State 10b. County	100	. City, Town or	Location					1	0d. Inside City Limits
	Ba-f.	cto	Maryland Baltimon	re	Essex							1 ☐ Yes 2 ☒ No
	th with the Maryland 23a or 28a-f ehow ust be notified at	Director	10e. Street and Number	- A		10f. 2	Zip Code 21221	1			of What Cour	ntry?
	death v	Funeral	962 Arncliffe Ro	12. Was Decedent Ever	in IIS 1	3 Was Day			nachi Vac ar N		Race - Americ	ean Indian
X	fter d	F	11. Marital Status 1 □ Never Married 2 Married	Armed Forces? 1XXes 2 ☐ No				lispanic Origin? (S an, Mexican, Puer	o Rican, etc.)	14.	Black, White,	
28	ours a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗌 Yes	2 XX No	Specify:		Sp	ecify: Whi	te
500	within 72 hours after ane. then "natural", or ite	Completed	15. Decedent's 8 (Specify only highest g	Education rade completed)	16a. De	cedent's Us	sual Occup	eation during most of wo	rking	16b. Kind	of Business/Inc	dustry
75	within	E G	Elementary/Secondary (0-12)	College (1-4or 5+)		a <i>DO NOT</i> ninist		d)		Ring	& Seal	Manufact.
(A)	be filed within tal Hygiene. ed other then event, it a m	ပိ	10 17. Father's Name (First, Middle, Las	t)				18. Mother's Nar	ne (First, Middle			
and	Mental Mental arked o	To Be	Ray Spangler	,				Beatrice			,	
25	s 1 and 2 should be filed withli F Health and Mental Hygiene. Item 27 is marked other then other traumatic event, IL a M	-	19a. Informant's Name/Relationship	(Type, Print)				and Number or Re				
Baltimore, Mary	is 1 and 2 of Health a item 27 is other tra		Virginia Spangle			-		Road, Ba	altimore	, Mary	yland 2	1221
	of He		20a. Method of Disposition 1 □ Burial 2 ☒️Xremation 3		b. Place of Dis cemetery, c				Date		ion - City or To	
	permit. Pages Department of Important; if it any injury or o		4 □ Donation 5 □ 9ther (Spec	B B	ayview							Maryland
Ball	permit. Departimport any inj		21 Signature of Familial Service Lice	ns.		22. Name	and Addres	ss of Facility ruzdzins	ki Funer	al Hor	ne, P.A	
91-2	10240	\leq	23a Part I Ent the disease or cor	nolications that caused the	teath. Do not	140	OTa	Eastern	Avenue,	Esse	x, Mary	land 21221 Approximate
			23a. Part1. Ent., the disease, or cor shock, of eart failure. List only	one cause on each line.	South. Do not	onto the th	ode or dylli	ig, such as caldia	or respiratory a	irest,		Interval Between Onset and Death
	Physician /Medical		Immediate ause (Final disease of condition resulting in death)	a	, D							
	Examiner				ooquance or).							
ik		Jer	Sequentially list conditions, if any, leading to immediate cause. Litter Universitying Cause (Disease or injury	Due to (or as a con	sequence of):							
10	e be executed ysicien and e burial-transit	Examiner	that initiated events	c								
760,	e exe		resulting in death) Last	Due to (or as a con	sequence of):							
687	9 5 0	dical	•	d								
»×	Attending Physicien: The law requires that the death certificat refath. ector: After this certificate hes been signed by the attending phy by the funeral director, page 2 should be dejached for use as the	Completed by Physician/Med	IF FEMALE:	23c. If yes, outcome of pre	egnancy					224	Date of delive	n.
B	eath atter	clar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time	Fetal death	3 □Ectopic 5 □ Other (′		230	. Date of delive Month	Day Year
o.	that the d ed by the detached	hys	9 Unknown	9□ Unknown						- 1		
Division of Vital Records, P.O. Box	es thai igned I be det	y P	Part II. Other significant conditions	contributing to death but not	resulting in the	e underlying	cause give	en in Part I.	23e. Did	tobacco use	contribute to th	e cause of death?
ğ	v require been sig should b	le d	Pheumonia						1×2	Yes 2□N	lo 3∏Prob	ably 4 ∐Unknown
မိ	law rees be	ple							24a. Was		4b. Were auto	psy findings available
<u> </u>	The law	Con							perfe 1 ☐ Yes	2 No	death? 1 ☐ Yes	
Vita	iicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			. 011	26. Place of Dea	ath (Check only	one		
o to	Phys this ral dir	10	1 Yes 2 No 27. Manner of Death	1 Ly Inpatient	2 ER/Outpat 28b. Time			4 Li Nursing F	lome 5 ☐ Res 28d. Describe	-		"
e e	ding I h. After funer	tou	1 Natural 5 Pending 2 Accident investigate	28a. Date of Injury (Month, Day Yea	r) Injur		28c. Injun Worl	k? Yes 2 □No	200. Describe	now injury or	CCUIT O U	
<u> </u>	Attendir death.	flea	3 ☐ Suicide 6 ☐ Could not	28e. Place of Injury - /	At home, farm,	street, facto	ory, office		28f. Location (Street and N	umber or Rura	l Route Number,
á	s afte	Certification:	4 Homicide	building, etc. (Sp	өспу)				City or To	wn, State)		
	To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the	cal	29a. Certifier Certifying P	hysician: To the best of my minar: On the basis of exam	knowledge, de	ath occurre	ed at the time	ne, date and place	, and due to the	cause(s) and	d manner as st	ated.
	the H in 24 the F nplete	Medical	one)	and manner stated.	THE REST AND OF				ired at the time,			
	wit To	2	29b. Signature and title of certifier	0-11911	٨	2	9c. License	e number		29d. Date s	igned (Month,	Day, Year)
	, ~ 1		- Wassa E	(-41+	~2	5::	D	01001		/	10/00	,
	51		30. Name and address of person who	TITE 9000	(Item 23a) (Typ	00, Print) _ 151	Drille	e Baltin	iore m	12 0	1237	
	St	ate	31. Date filed (Month, Day, Year)	32, Registrar's S	ignature	, ,	1110)	0 - 00		
	Regist		4 0 000	oc Zo	20 1	A. M. 2						

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2006 1 - For State Registra 29063 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Scher merhorr Sept. 4, 2006 5:20 am auline /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Prince Georges Marineer Health Care If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 M 2 F 579-20-1321 81 Yrs. Director April 9, 1925 Washington DC Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or Items 23a or 28a-f show The Medical Examiner must be notified at 1 Yes 2 □ No Maryland Prince Georges Laurel Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with 9010 Briarcroft 20708 United States America or Iteme 23a death Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Item any injury or other traumatic event, the Musical Examination. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baitimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White ģ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Accounting Bookkeeper 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Athena Nathan Peter Kanelopoulos 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary Boyd/Daughter 136 Blackburn Drive Nottingham PA 19362 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville Vet. Cem. 9/7/2006 Crownsville, Maryland 21. Signat - of Fundal Service Licensee 22. Name and Address of Facility non Fleck Funeral Home 7601 Sandy Spring Road Laurel MD 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death 3yrs Immediate Cause (Final disease or condition resulting in death) Senile Dementia of Alzheimers Type Physician /Medical Due to (or as a consequence of): Examiner Hyperthrophic Cardiomyopathy 5yrs Esquentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine ed by the attending physicien and detached for use as the burial-transit requires that the death certificate be executed 3yrs Cardiac Arrhythmia Due to (or as a consequence of). P.O. Box 68760 Physician/Medical 10yrs Mypertonia d IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown s been signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? The law s certificate has t director, page 2 s 2□ No 1 Tyes 1 Yes _2 🗆 No or Attending Physician: director Be 25. Was case referred to medical 26. Place of Death Check on y one Hospital: Other: Certification: To 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 □Other (Specify) this ctor: After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 Thomicide within 24 hours a 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier anc 09/07/2006 D13671 30. Name and addre is of person who completed cause if death (Item 23a) (Type, Print) 14201 Laurel Park Drive MD 20707 B.G. Manejwala, MD Laurel 31. Date filed (Month, Day, Year) 32. Registrar's Signature Coases State 3 2006 PALLE Registrar

State of Maryland / Department of Health and Mental Hygiene 2006 29064 For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 0,2006 Physician Salvino September 1:20 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore 6802 Deluth Avenue Dundalk If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F 214-12-4066 84 Yrs. January 15, 1922 Maryland Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County r then "naturel", or itame 23a or 28a-f ehow tre Medical Examiner must be notified at 1 Yes 2XXNo Dundalk Directo MD. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after deeth v Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel, or items 23a any injury or other treumatic event, the Medical France. IISA 21222 Funeral 6802 Deluth Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: ģ White 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clothing Seamstress 8 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maddelene Goeb George Salvino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3116 Lynch Road, Baltimore, Md. 21222 Francis Salvino Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition September 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart Of Mary Cem. 12, 2006 4 ☐ Donation 5 ☐ Other (Specify) Dundalk, MD. 21. Signature of Funeral Service Licensee ²²Connelly Funeral Home Of Dundalk, P.A. 21222 7110 Sollers Point Road, Dundalk, MD. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Pracy ¥Physician Carco Ray /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner or Attending Physician: The law requires that the death certificate be executed as the burial-transit physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an this certificate 1 ☐ Yes 24 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 SKNo 28c. Injury at Work? s efter death. Certification; 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours e To the Funerel C 29a. Certifier 🖙 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier D19714 W 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 4940 Exellen are BUNK Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 U U 6 Certificate of Death 1. Decedeni's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Yeer **Physician** PM Leon Taylor 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Crescent Cities Nursing Home Riverdale If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. May 3, 1930 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1⊠M 2□F Director 230-76-4656 May 76 Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10a. Slate 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at 1 Yes 2 No Director Riverdale Prince Georges 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? with 4409 East West Highway deeth v Funerai USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: It item 27 Is marked other than "natural", or Ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: þ Specify: 3 Widowed 4 Divorced black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 painter none self-employed 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Thomas Taylor Ethel Corson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2916 Old Court Rd. Baltimore, MD 21208 Melva Jones/sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: It any injury or once. injury or `4 □Donation 5 🕱Other (Specify) in state State Anatomy Board 655 W. Baltimore Street baltimore, MD 21201 Ronald S. Wade Virector Dairimore, MD 21201

23a. Part Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Herroschenotic Cardio Vasculan Diseus Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed as the burial-trans and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physicien Completed by Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No detached 9□ Unknown 9 Unknown ģ Part J- Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be Call Consinoner torque 1 Yes 2 No 3 Frobably 4 Unknown peen : 24b. Were aulopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy 1 ☐ Yes 2 ☐ No 2 2 No or Attending Physician: filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, elc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide the Hospital within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Chack only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 6 Februar Love 01852 30. Name and address of peril who completed cause of death (Item 23a) (Type, Prict) veensbury Polity attsville MD 20181 OREMD 42034 22. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar SEP 1 3 2006

_			1 - For State Registrar	State of Ma	ryland / De	epai C <i>ert</i>	ificate of l	Death		Reg. No.	006	29066
	Physici /Medi		1. Decedent's Name (First, Middle, Last, Marvin L. Terry)					2. Date of De Month Septem	ber 8,	2006	3. Time of Death 11:30 AMM
	Examir		4a. Facility Name (If not institution, give Joseph Richey Hos					Location of Death		4c. Count	y of Death	
	Funeral Director		5. Social Security Number 6. Sec. 12 6. Sec.		(In yrs. last birth	- 1	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Nov 5,	h y, Year) 1960	9. Birthp Coun Virgi	lace (State or Foreign try) inia
-	aryland show	J.	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town		ation				1	0d. Inside City Limits
	with the Maryland a or 28a-f show the notified at	Director	MD Prince Geo 10e. Street and Number 4663 Winter Berr		Oxen H	111	10f. Zip Code	20745		10g. Citizen of	What Coun	
036	within 72 hours after death with the Maryland ene. hen matural; or items 23a or 28a-f show he Mardicel Executive court be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Dovorced	12. Was Decedent E Armed Forces? 1 XI Yes 2 No If Yes, Give Year or Dates:			as Decedent of H Yes, specify Cuba ⊇Yes 2∏No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Bla	ace - Americ ack, White, ify: bla	etc.
$\#\mathcal{JO}_{\mathcal{OM}}$ Baltimore, Maryland 21215-0036	d within 72 ho giene. or then "natur	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+	16a. D	Give k life. Di		ation during most of work d) manager	ing	16b. Kind of E		dustry
nd 2	be filed tal Hygie d other event, it	Be Co	17. Father's Name (First, Middle, Last)			10	Scaurant	18. Mother's Name		Maiden Suma	me)	
ıvla	should k nd Ment market umatic	ို	Marvin Terry Sr 19a. Informant's Name/Relationship (7)	γρe, Print)	196. 1	Mailing	Address (Street a	Beu. and Number or Run	lah Mae			Code)
S S	s 1 and 2 should be filed w f Hauth and Mental Hygier (1em 27 is marked other it other treumatic event, Ital		Anthony Jones/f	riend	20b. Place of D			Berry La	ne oxen	Hill,		0745
30am	permit. Pages 1 an Department of Heal Important: If Item 2 eny Injury or other <u>once</u> .		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 🗓 Other (Specify)	in state	cemetery,	, crema	atory`or other plac	(e)		EGG. EGGGRIGH	Oily of 10	, ciaio
≫ // Bal	permit. Departm Imports eny Inju		21. Signature of Fineral Service Licens ROnald S. V	Vade, Dire	ctor	$ St ^2$	Name and Address time Anato	omy Roard	655 W.	Baltim	ore S	treet
	Physician /Medical		23a. Part Lienter the disease or complished, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a	the death. Do not e. Cholana	10	the mode of dyin	ig, such as cardiac	or respiratory ai	rrest,		Approximate Interval Between Onset and Death
/ <i>O</i> (<i>O</i> 68760.	The law requires that the death certificate be executed as the has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	consequence of	·):						
9/8/ Box	that the death certified by the attending detached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	2 ☐ Fetal death		Ectopic pregnancy Other (specify)	1	70 S. S.		ate of delive	ery Day Year
ر ارم S. P.O	quires that the name of signed by a detaction	5	Part II. Other significant conditions co	ntributing to death bu	t not resulting in t	the und	derlying cause give	en in Part I.		obacco use cor Yes 2 No	ntribute to th	ne cause of death?
7 ery	The law requi	Completed									prior to cor death?	psy findings available mpletion of cause of
Marvin Terry Division of Vital Records.	Attending Physician: The rideath. sctor: After this certificate his y the funeral director, page	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Mamer of Death Natural 5 Pending investigation	3 DOA Oth 28c. Injun Worl M 1	4 Nursing Ho		dence 6 00	ther (Specify	Hospice			
Divis	To the Hospitel or Attenwithin 24 hours after deatl To the Funaral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju- building, etc.	ry - At home, farr . (Specify)	n, stre	et, factory, office		28f. Location (: City or Tox		nber or Rura	l Route Number,
	To the Hospitel or within 24 hours after To the Funaral Dir completely filled in	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 ☐ Medical Exam	rsician: To the best o iner: On the basis of and manner stat	examination and	death /or inve	occurred at the tine estigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and n date and place	nanner as si	ated. the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifier				29c. Licens			29d. Date sign		
			30. Name and address of person who c	ompleted cause of de	eath (Item 23a) (T	ype, P	rint) = 1	CL	Balti	201	100 m	2170)
	St	ate	31. Date filed (Month, Day, Year)	32. Progistra	s Signature	>5	NEW	awst	patr	mere,	MU	461
	Regist	rar	SFP 1 3 20	Ub BEELA	as Dr.	A Contract of the	BARE					

State of Maryland / Department of Health and Mental Hygiene 2006 29067 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year September 12, 2006 10:10 A.M Physician Carolyn Virginia Thomas /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/AHarborside Healthcare Harford Gardens Baltimore 8. Date of Birth (Month, Day, Year Dec. 26, 1 If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Sex Funeral 1□M 2XX 1932 West Virginia 73 Yrs. 212-32-2872 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County worle rthan "natural", or items 23a or 28a-f eho 1XX es 2 □ No **Funeral Director** Baltimore Maryland N/A10f. Zip Code 10g. Citizen of What Country? United States 10e. Street and Number 21214 4700 Harkord Road of America 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify Completed by 3XWidowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) jes 1 and 2 should be filed within 7 of Health and Mental Hygiene. If Item 27 is marked other than "r or her traumatic event, the Med Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Florence Bernice Calvert Harry Lester Wilhelm ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pasadena, Maryland 21122 1124 Wharf Drive; Robert N. Thomas (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 5 = 6 1 Burial 2 (ACromation 3 Removal from State 4 Donation 5 Oher (Specify) permit. Page Department of Important: If eny Injury or once. Bayview Crematory, Inc. 9/13/2006 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Home, Inc.
3331 Brehms Lane
Baltimore Manufand 21213 21. Signature of Higher Service 1 Approximate Interval Between Onset and Death Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardi/c respiratory arrest, slock, or heart failure. List only one cause on sich line. tate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 Yes 2 No Day 4☐ Pregnant at time of death 5 Other (specify) signed by the at I be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death Check only ne Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 1 🗌 Inpatient 2 ER/Outpatient 3 DOA ဥ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Feath . After al or Attending F after death. I Director: After Certification: 1 Natural 5 Pending 1 Yes 2 No investigation To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Mu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 601-60 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

06-06783

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Biafria Thomas Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2 Date of Death Physician/ Month Day September 8, 2006 1455 hrs Biafria C. Thomas Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (if not institution, give street and number) Baltimore 4131 Raymonn Ave 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7 Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number 6 Sex **Funeral** Foreign Months Hours Davs Country) MD Director M 2X F 213-90-4332 36 01/28/1970 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a State 10b County MD n/a Baltimore City 1 X Yes 2 No 28a-f show notified at once. 10g Citizen of What Country 10f. Zip Code 10e. Street and Number 4131 Raymonn Ave 21213 USA ā 23a13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' 1 XNever Married 2 Married 2 X No Yes Yes 2 X No specify: Specify: Black f Yes, Give Year Widowed 4 Divorced à d 2 should be filed within 72 hours aft Ith and Mental Hygiene n 27 is marked other than "natural" aumatic event, the Medical Examin 16a Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) 12th unknown MD 21215-0036 nursing Assisted Living 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles E. Thomas Ruthie Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ruthie Thomas / Mother 3516 Cliftmont Ave; Baltimore, MD 21213 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Saltimore, crematory or other place) Burial 2 Cremation 3 Removal from State Mount Zion Cemetery 09/15/2006 Department o Important: injury or oth Baltimore, MD Donation 5 Other Specify 22 Name and Address of Facility Signature of Funeral Service Licenses Wylie Funeral Home, P.A. 1638 N. Gilmor Street: Raltimore, MD 21217 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval Part I. Enter the disease, dr Physician Between Onset and failure. List only one cause on each line. /Medical a. Strangulation Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) events resulting in death) Last sician/Medical UNPENDED X AMENDED item#8.perME.g859.9/13/06 TT Box 68760, 23d Date of deliver IE EEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown Unknown Phy 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I P.O. 1 Yes 2 ✔ No 3 Probably 4 þ Completed Division of Vital Records, 24a. Was an 24b. Were autopsy findings available autopsy performed? prior to completion of cause of death? ✓ Yes 2 ✓ Yes 2 No After this certificate 26.Place of Death (Check only one) 25. Was case referred to medical the Hospital or Attending Physician: Be Other₄ Hospital. Nursing Home 5 Residence 6 ✓ Other: Scene ER/Outpatient 3 Inpatient 2 1 🗸 Yes 28a Date of Injury (Month, Day, Year) FOUND: 28d Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death Certification: Subject was strangled FOLIND Natural Yes 2 V No 5 Pending after death Director: Sep 8, 2006 1445 hrs Accident 28f Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 Could not be Suicide or Town, State) 4131 Raymonn Ave, Baltimore, MD (Specify) Home within 24 hours al To the Funeral E determined 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started cal 2 Will Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d Date signed (Month, Day, Year) 29c License number 29b. Signature and t September 9, 2006 O.C.M.E. ed cause of death (Item 23a) 30 Name and ad ss of rson 111 Penn Street, Baltimore, MD 21201 Deputy Chief Medical Examiner Mary G. Ripple MD. 31. Date filed (Month, Day, Year) State Registra

ORIGINAL

DEXTER A. Turner Sr. 06-06669 UNK UNK

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

ATT OTHE		For State	Ce.	rtificate of			Reg	No. 2	nns sans		
Physician Medical Examine	1	Decedent's Name (First, Middle, L Dexter A. Turr	,				 Date of Death Month September 	Day Year 6 2006	0135 hrs		
incaroar Examinic		a. Facility Name (if not institution, ç	give street and number)	41	o. City, Town, or Loc	cation of Death	Coptombol	4c. County of			
		Northbound Route 3 and 5. Social Security Number 6.	I Route 424 Sex 7. Age (In yrs.	ast hirthday)	Crofton If Under 1 Year	If Under 24Hrs.	8. Date of Birth	Anne Aru			
Funeral Director		011 50 0110	M 2 F	57 Yrs.	Months Days	Hours Min.	Jan 10		9. Birthplace (State or Foreign Country D. C.		
any	r	10a State 10b. County 10c. City, Town or Location 10d Inside City Limits									
Aaryland 28a-f show 1 at once.	₽M E -	aryland Anne A	Arundel Ann	apolis	10f. Zip Code		140	g. Citizen of Wha	1 X Yes 2 No		
ith the Maryland 23a or 28a-f she notified at once	ě	10e Street and Number 20 Heritage Ct			21401			USA			
Baltimore, MD 21215-0036 pernit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Marri	1 Yes 2X No	If Ye	Decedent of Hispar s, specify Cuban, M	lexican, Puerto I		White,	American Indian, Black, etc.		
urs afte	⋧├	3 Widowed 4 Divorce 15. Decedent's Education (Specify	led If Yes, Give Year or Dates.	16a. Decedent	Yes 2 X No s s Usual Occupation	(Give kind of w		16b. Kind of Bus			
imore, MD 21215-0036 Pages I and 2 should be fited within 72 hours af near of Health and Mental Hygiene. and the fiten 27 is marked other than "natural or other traumatic event, the Medical Examin	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		st of working life. DO			TT1 11 1			
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Ę	10th 17. Father's Name (First, Middle, La	o O	Cons	truction 18.		(First, Middle, M	Whitin aiden Surname)	g Turner Co.		
1215 be file ental He irked o	å L	Allen Turner S					ne Bro				
MD 21 nd 2 should B atth and Mer m 27 is mar To 1	-4.	19a. Informant's Name/Relationship Jacquelyn Turi		2.0	Address (Street a ritage C						
e, W I and 2 Health Titem 2	ı	Jacquelyn Turner(Wife) 20 Heritage Ct. Annapolis, Md. 21401 Oa. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State Crematory or other place)									
Baltimore, MD 2121. Permit Pages I and 2 should be fill pages I and 2 should be fill pagarment of Health and Mental I important: If ritem 27 is marked nijury or other traumatic event, and the page of the page o	1	4 Donation 5 Other Spec	Eb	enezer	AME Chu				ille, Md.		
Balt permit Departs Import		21. Signature of Funeral Service Lie		Wm	me and Address of Reese	& Sons	Mortu	ary, P	.A.		
Physician	- 19	Zazzy A. Rees 23a Part I. Enter the disease, or co failure. List only one cause or	mplications that caused the death	n. Do not enter th	e mode of dying, su	ch as cardiac or	respiratory arre	st, shock, or hea	rt Approximate Interval Between Onset and		
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68760, certificate be nding physicilise as the buri		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pre		al death 3	Ectopic pregna	ncv	23d. Date of o	delivery Day Year		
Box 68 to death certification the attending red for use as to death certification to be as to death de	iciar	past 12 months?	4 Pregnant at time of d		al death 3 ner (Specify)	Letopie progna	iley .	Monar	Day Four		
the death the atte	Physician/	1 Yes 2 No 9 Unkno	9 OHKIOWII	resulting in the u	nderlying cause give	en in Part I.	23e Did tot	bacco use contribute to the cause of death?			
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Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rs after death. "al Director: After this certificate has been signed by led in by the funeral director, page 2 should be deach	١	1 Yes 2 No 27. Manner of Death	28a Date of Injury	28b. Time of I		at Work?	28d Describe h	ow injury occurre			
ion trendin death. tor: A	atio	1 Natural 5 Pendin 2 Accident Investi	gation	0120 hrs		s 2 🗸 No					
Divis al or A s after al Direct	Certification:	3 Suicide 6 Could			t, factory, office buil		or Town, St	ate)	er or Rural Route Number, City 424, Crofton, MD		
hou hou		4 Homicide 29a Certifier 1 Certifying Phy	sician: To the best of my knowle		red at the time, date						
환경 등 전 one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due and manner stated											
	Σ	29b. Signature and title of certifier	210,		29c. License r			September	ed (Month, Day, Year) 6, 2006		
		30. Name and address of person w	ho completed cause of death (Ite	m 23a)		-					
3		Zabiullah Ali, M.D. A	ssistant Medical Examine	er 111 Pen	n Street, Baltim	nore, MD 21	201				
Sta Registr	100		32 egistrar's Signa	ture doe	B.S						
	_		4-1-6-6-4	25-52							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 3. Time of Death 1 Decedent's Name (First, Middle, Last) BENJAMIN **Physician** 600 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Ellicott City Howard Ellicott City Health & Rehab Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 80 Director 217-20-7066 April 25, 1926 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🗷 No Director Howard Ellicott City Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 21043 U.S.A 8537 Frederick Rd by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 DYes 2 DNo If Yes, Give Year or Dates: 195 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Never Married 2 Married 1952 Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☑ No Specify Black 3 Widowed 4 Divorced 1956 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Clerical Elementary/Secondary (0-12) College (1-4or 5+) is marked other than Lab Technician unk 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fit Department of Health and Mental Hy importent: If Item 27 is marked other any injury or other treumastre 17. Father's Name (First, Middle, Last) Be Annie Mae Griggs John Henry Tyler 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8537 Frederick Rd. Ellicott City, Maryland 21043 Wife Mrs. Ruth Tyler 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Remoyal from State 09/13/2006 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Park, Inc. 21 signature of Furjeral Service License 22. Name and Address of Facility Slack Funeral Home, P.A. 1400533 3871 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Deat Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final Physician /Medical resulting in death) **Examiner** Sequentially list conditions, Due to for as a consequence of, Examiner rr any, leading to immediate cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed physiclan and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Tectopic pregnancy 1 Live birth 2 Fetal death Month Day ŏ 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No P.0 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 3 ☐ Probably 4 ☐ ☐ Known 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy s certificate has director, page 2 performed' 2 No 1 Yes 1 □ Yes 2 🗇 Division of Vital or Attending Physicien: 25. Was case referred to predical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Be Other: Mirsing Home 5 Residence 6 Other (Specify) Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Mann of Death 28b. Time of 28a. Date of Injury (Month, Day Year, 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: / completely filled in by the f 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide the Hospitei t 🔀 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) fand manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier cause of death (Item 23a) (Type, Print) 30. Name and address of person who complet CONOR 32. Registrar's Signature 31. Date filed (Month, -Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 2006 29071 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 6, **Physician** 2006 1:28 p M Kitsa C. Vlachos /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Bel Air Lorien - Bel Air If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
June 11, 1951 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Hours 1 □ M 2 □ F Yrs Greece 216-58-3359 55 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits r than "natural", or items 23s or 28s-f show the Medical Exerciner must be notified at Md. Bel Air Harford 14 Yes 2 □ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21014 U.S.A. 516 Woodbury Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 28 Married Specify: white 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) insurance insurance adjuster 12 years if item 27 is marked other or other traumatic event, aryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ould be f Mental Nina (unknown) Gustos Mitsos of Health and M 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 516 Woodbury Way, Bel Air, Md. 21014 Ted Vlachos/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 9/11/2006 Bel Air Mem. Gdns. Bel Air, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC LUNG CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner The law requires that the death certificate be executed ending physicien and use as the burial-transil Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown signed by t i be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate hes been signage 2 should b OBSTRUCTIVE CUN G 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 No 1 Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death | Check only one examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: Medical Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) his 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and little of certifie 29c. License number 29d. Date signed (Month, Day, Year) D45344 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6225. UNION AVE, HATRE DEGRACE, MA 21078 DHANJANI 32. Pegistfar's Signature 31. Date filed (Month, Day, Year) State Pales 2006 Registrar

DHMH 17 Rev 1/2001

V

ACANSA

State of Maryland / Department of Health and Mental Hygien 2006 29072 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 09/05/2006 **Physician** Robert Charles VanOrden 12:00PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 618 Powhaten Beach Road Pasadena Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 01/13/1940 **Funeral** Birthplace (State or Foreign Country) Days Hours 1 0 M 2 □ F Months Director 261-58-1713 66 WA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or Itams 23a or 28a-1 show the Medical Examinar must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 618 Powhaten Beach Road 21122 U.S.A. hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1XYes 2□No 1959 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: ð Specify: 3 ☐ Widowed 4 ☐ Divorced 1981 White Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry tiled within 72 Elementary/Secondary (0-12) United States College (1-4or 5+) 5+ Gunner Air Force marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental traumatic Gene Robert VanOrden Bernice Loretta Doman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 09 Health Deborah VanOrden/Wife 618 Powhaten Beach Rd., Pasadena, MD 21122 If item 27 other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Peges 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Pege Department of Importent: If any injury or once. injury or `4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 09/09/06 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility G.J.Gonce Funeral Home, 169 Riviera Drive, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on __ch line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a cons Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ettending physician and tor use as the burial-transit The law requires that the death certiticate be executed oronary Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) ed by the detached signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed cate 1 Yes 2 No Hospital or Attending Physician: certific director, Be 25. Was case referred to medical 26. Place of Death | Check only one examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No P this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Atter s atter dea. 1 Natural 5 Pending 1 TYes 2 TNo investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide ∆ 24 hours the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) Type, Print) (Win Doyle M.D. 1417 Madison Fark Offi Goerte 31. Date filed (Month, Day, Year) 32. Registrar's Signature SEP Registrar

State of Maryland / Department of Health and Mental Hygiene 200629073 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year September 9, 2006 **Physician** 2:10 P M Vogel /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore 6532 Corkley Road Rosedale 8. Date of Birth (Month, Day, Il Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year Months Days Hours 1**X** M 2 □ F 214-44-6564 60 Yrs. November 21,1945 Maryland **Director** Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "naturel", or Items 23a or 28a-f ehow The Medical Examiner must be rediffed at 1 ☐Yes 2X No Directo Rosedale Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6532 Corkley Road 21237 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after tv Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: White ğ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Service Technician Dental Supplies 12 years ps 1 and 2 should be filed of Health and Mental Hygis If itsm 27 le marked other in other traumatic event, It 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Doris Hurley John Vogel Jr. Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6532 Corkley Road, Rosedale, Maryland 21237 John Michael Vogel son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State September 5 <u>=</u> 5 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department i Importent: If eny Injury or once. Oak Lawn Cemetery 13, 2006 4 ☐ Donation 5 ☐ Other (Specify) Dundalk, MD. re ol Funeral Service License Connelly Funeral Home Of Dundalk, P.A. 21222 7110 Sollers Point Road, Dundalk, MD. 23a. Part. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death o not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** acontes Cance disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dire to (or as a nonsequance of): Examine ysicien and e buriat-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical as the attending phys IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year signed by the aid be detached for 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy lindings available prior to completion of cause of death? s certificete has b 24a. Was an 1☐ Yes 2 No 1 Yes 2 No Division of Vital or Attending Physician: : After this certification : After this certification : Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification; To 1 Yes 2 No 1 Inpatient 2 EN/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending s efter death.
I Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place ol Injury - At home, farm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours e To the Funeral [Hospitel 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D58303 September 11 2006 30. Name and a sess of person who completed cause of death (Item 23a) (Type, Print) N. Charles St Browns up 21204 6601 MERRA 31 Date liled (Month, Day, Year) 32. Registrar's Signature State 2006 Registrar

			For State Registrar	State of	Maryla	and / Dep <i>Ce</i>	artment ertificate			Mental H	Hygiene Reg. No			0.0	071
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	Examir	ier	4a. Facility Name (If not institution, given Suburban Hospita		Her)		Bethe		ation of Dea	ut		ntgom			
	Funeral		5. Social Security Number 6. S	өх 7	Age (In y	rs. last birthday	If Under 1	Year If	Under 24 Hrs	8. Date of	Birth Day, Year)		Birthplace Country)	(State o	r Foreign
	Director		092-03-5820	□M 20XF	92	Yrs.	Months	Days F	iours Min	May	12, 19	14 N	ew Yo	ork,	NY
_	and		Usual Residence of Decedent 10a. State 10b. County		10c.	City, Town or I	ocation						10d.	Inside Ci	ty Limits
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	n the	lrec	10e. Street and Number	-)			10f. Zip C	ode			10g. Cit	izen of What	Country?	?	
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	ar dee	unei	11. Marital Status	12. Was Deced Armed Force	es?	n U.S. 13	. Was Deceder If Yes, specify	nt of Hispa Cuban, N	nic Origin? (Mexican, Pue	Specify Yes or to Rican, etc.)	No-	14. Race - A Black, V	merican I /hite, etc.	Indian,	
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ly.	s 1 end 2 should if Health and Mer item 27 is marke other traumatic	ř	19a. Informant's Name/Relationship (Type, Print)		19b. Mai	ling Address (S				m <i>ber</i> , City o	r Town, Stat	e, Zip Coo	de)	
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Baltimore,	permit. Pages 1 Depertment of H Important: If ite eny injury or ott		21. Signature of Funeral Service Licer	1960 Ch	lein		Sherman 1283 Co								
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2	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1	nysician: To the bas miner: On the bas and manne	is of exam	knowledge, dea nination and/or	ath occurred at investigation, in	the time, on my opinion	date and place on, death occ	e, and due to urred at the tir	the cause(s) ne, date and	and manne place, and	r as stated due to the	d. cause(s)
3	To the Complete Compl	Σ	29b. Signature and title of certifier	. (29c. t	icense nu	ımber		29d. Da	te signed (M	onth, Day	, Year)	
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	6		30. Name and address of person tho Enrique Daza, M.I	-		(Type 600 01d		t Our	Rd.	Bethes	da. MT	2081	4		
	Str	ate	31. Date filed (Month, Day, Year)	32.	gistrar's Si			WII	,		,				
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** SEPTEMBER 9, 2006 Clarence Anthony Wiggers 10:15 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Pec. 7, 19 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1X M 2□ F 216-05-4905 1914 Maryland Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits r then "natural", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at Be Completed by Funeral Director 1 ☐ Yes 2 X No Parkville Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 u.s.A. 8810 Walther Blud., Apt. 1114 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. important: if item 27 ie marked other then "natural, or iteme 23a enty injury or other treumatic event, the Madical Examiner must benear 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Specify: 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Supervisor Western Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Clarence Wiggers Veronica Uzmed ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9809 Woodbridge Ct., Ellicott City, MD 21042 Ann Stallings (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Gardens of Faith Cem. 9/13/2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilitySchimunek Funeral Homes 21. Signature of Funeral Service Licensee, 9705 Belair Rd., Baltimore, MD 21236 23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CONGESTIVE HEART FAILURE /Medical Due to (or as a consequence of) Examiner BILATERAL PLEURAL EFFUSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner sicien and burial-transit The law requires that the deeth certificate be executed ACUTE RENAL FAILURE Due to (or as a consequence of): Box 68760. phys. IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page #med? 2⊠No 20 No 1 Yes 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 / Inpatient Medical Certification: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending efter death. I Director: Aff d in by the fur 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours efter within 24 hours of To the Funeral filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day Year) 29c. License number 29b. Signature and title of certifier D41410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER DRIVE TOWSON MARYLAND JOGINDER P. MEHTA. M. D. 7301 31. Date filed (Month, Day, Year) 32 Registrar's Signature State SEP 1 3 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 2006 29076 1 - For State Registrer Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** WEIMER 1 wood 2006 104 AM JUST /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PARKWAY NUTSING Perring Park 5. Social Security Number PARKUIlle BALTIMERE Home Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday).
Yrs. 6 Sex Birthplace (State or Foreign Country) **Funeral** 208-14-7628 12 M 2□ F Months Days Hours Min Director Usual Residence of Decedent the Maryland 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location Itam 27 is marked other then "natural", or Items 23a or 286-f show other traumatic event, the Madical Examinar must be notified at 1 Yes 2 No MD BALTIMORE PARKUILLE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A 7815 CLARKWORTH . PL 21234 death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1276s 2 □ No Û, 5 If Yes, Give Year or Dates: ARMA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. In portant: I free important: if Itam 27 is marked other then "naturel", or iter any injury or other traumatic event, the Medical Examination. Since. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: white 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12+0 Steele WORKER ARMCO STeele NIn 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNKNOWN HOWARD Weimer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 602 Churchhill RD William Weimer BelAVA MA 11. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, Slate Burial 2 ☐ Cremation 3 ☐ Removal from State 9/15/06 5 HAMOKIN ST 4 □ Donation 5 □ Other (Specify) Peters cem. 22. Name and Address of Facility
PAUL STELLA FUNERAL Home, DA
7.527 harford Rs. Balto. Mb 21234 21. Signature of Funeral Service Licensee 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Adoltic Anuryzm Repture disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner CH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed CAD Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were aulopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? Dorferd Viscular To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending 24 hours after death.

Funeral Director: A 1 Tyes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier SEPT 11,2006 D 0064104 D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SISTANI SIMIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Goods Registrar Elecas.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 🛭 🗎 🔓 For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Month Vear 9.30 AM CARROLL WILSON 8 2006 SEPTEMBER 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) BALTIMORE HARBOR HOSPITAL If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 100M 2□ F Months Days 84 Yrs 178-13-1414 Usuel Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a State 1 Yes 2 No BURNIE GLEN MD. ANNE ARUNDEL 10g. Citizen of What Country? 5A orina Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ev Armed Forces? 1 2 Yes 2 No dent Ever in U.S. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 TNo Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) LOCAL 26 Elementary/Secondary (0-12) College (1-4or 5+) IBEW ELECTRICIAN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ZUFALL CARROLL WILSON LOUISE AMOS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) /SPOUSE BARBARA CLEARSPRING GLEN BURNIE CT. 20a. Method of Disposition

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 9-11-06 ELKRIDGE MD. MEADOWRIDGE MEMORIAL 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4001 RITCHIE HWY 21225 FUNERAL SERVICE P.A. BALTO. MD. womenusk Approximate Interval Between Onset and Death 23. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure? I not only one cause on each line. Immediate Cause (Final disease or condition resulting in death) LOCALIZED ADVANCED LUNG CANCER ONE MONTH Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 2 2 No 1 Yes PULMONARY DISEASE 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No

/Medical Examiner Attending Physician: The law requires that the death certificate be executed of Vital Records, P.O. Division within 24 hours etter death.

To the Funeral Director: Af
completely filled in by the fur ō

Physician

/Medical

Examiner

Funeral

Director

Itama 23a or 28a-f ahow

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. Pages 1 and 2 should be fil ment of Health and Mental H tent: If Item 27 Is marked oft Jury or other traumatic avan

permit. Page Depertment o Importent: If any Injury or ance.

Physician

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the Medical Examiner must be notified at

Funeral Directo

Completed by

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with the Maryland

filed within 72 hours after death

21215-0036

Baltimore, Maryland

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury Completed by Physician/Medical Examiner resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE HYPERTENSION CHRONIC OBSTRUCTIVE 25. Was case referred to medical examiner? Medical Certification; To Be 1 Yes 2 No 27. Manner of Death 1 Natural investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number

PHYSICIAN

RES 000

29d. Date signed (Month, Day, Year) september, 8, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

21225 THAHIRA AHAMED, 3001 SOUTH HANDVER ST, BALTIMORE, MD 31. Date filed (Month, Day, Year)

Registrar

32. Registrar's Signature

SEP 1 3 2006 California S.

		1	For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of Hertificate of I	lealth and M Death	1ental Hygi	ene 2006	29078
	Physicia	an	1. Decedent's Name (First, Middle, Las Kathleen	Eliza	abeth	Wagner		2. Date of Death Month Septembe	r 10,2006	3. Time of Death 8:20 PM
ı	/Medic Examin	er	4a. Facility Name (If not institution, given 13116 Choptank Roa			4b. City, Town, or Chase	r Location of Death		4c. County of Death Baltimo	
	Funeral Director		5. Social Security Number 6. Se		e (In yrs. last birthday 63 Yrs.) II Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 7,	9. Birth 1943 Mary	place (State or Foreign Intry) 71and
	ס		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits
	vith the Ma	Directo	Maryland Baltimore 10e. Street and Number		Chase	10f. Zip Code	21220	10	g. Citizen of What Co	*
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other then "netural", or items 23a or 28a-f show mimportant: If item 27 is marked other then "netural", or items 23a or 28a-f show appring hyging or other treumatic event. I'm Medical Examinar must be notified at another.	by Funeral Director	13116 Choptank Ro	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:		. Was Decedent of H II Yes, specify Cuba		pecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh	ican Indian, o, etc.
Maryland 21215-0036	I within 72 hou ilene. r then "netura the Medical E	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12	ducation de completed) College (1-4or 5	(Giv life.	edent's Usual Occup e kind of work done DO NOT use retired Secretary	ation during most of work d)	king	6b. Kind of Business/I Internal Re	^{ndustry} evenue Serv.
and	t be filed ntal Hyg ed other: event.	Be	17. Father's Name (First, Middle, Last) James Bernare				18. Mother's Nam Berth	ne (First, Middle, M a Made		ilczynski
Mary	12 shouk h and Me 7 is mark reumatic	<u>۲</u>	19a. Informant's Name/Relationship (Edward Wagner Jr.				and Number or Rui nk Road C	ral Route Number, hase Mary	City or Town, State, Z yland 21220	ip Code)
Baltimore, I	ages 1 and ant of Healt t: If item 2 y or other		20a. Method of Disposition 1 № Burial 2 □ Cremation 3 □ 4 ▶ Donation 5 □ Other (Specify	Removal from State	20b. Place of Disposemetery, or Holly Hi	ematory or other plai	ce)		oc. Location - City or	Fown, State D., Maryland
Baltir	permit. P Departme Importan any injur.		21. Signature of Puneral Service Licer			22. Name and Addre	ss of Facility B	ruzdzinsl	ki Funeral ex Marylan	Home PA
	Physician		23a. Part1. Enter the disease, or lom shick, or heart failure. List only Immedia so ause (Final disease or condition resulting in death)	a. Autustus	hic honen					Approximate Interval Between Onset and Death
	/Medical Examiner			Due to (or as	a consequence or,			U	8	
	and I-transit	Examiner	Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):					
8760,	cate be executed physicien and s the burial-transit			_ d,						
P.O. Box 6	ath certifi ttending I or use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ≅ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	B⊟Ectopic pregnanc i⊟ Other (specify) _	у		23d. Date of del Month	ivery Day Year
	that ed b deta	by	Part II. Other significant conditions of	ontributing to death b	but not resulting in the	underlying cause gr	ven in Part I.		eacco use contribute lo	the cause of death?
of Vital Records,	The law requires tate has been sign page 2 should be	Completed						24a. Was ar autops perforn 1 Yes 2	y prior to o death?	topsy findings available completion of cause of 2 No
Vita	Physician: 1 this certifical ral director, p	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpati	ient 2 ☐ ER/Outpat	ient 3□ DOA Ot	200	th (Check only on	e) ince 6 □Other (Spe	0.6.1
		lon; To	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b. Time	of 28c. Inju		28d. Describe ho		ony)
Division	or Attendition of Att	Certification;	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	28e. Place of In	njury - At home, larm, etc. (Specify)		7 100 2 2 3 110	28f. Location (St. City or Town	reet and Number or Ro , State)	ıral Route Number,
_	pita ours veral	edical C	150 Certifier 150 Certifying Pt (Check only one)	hysician. To the best miner: On the basis of and manner s	of examination and/or	ath occurred at the tr investigation, in my	nie data and plana opinion, death occu	and due to the as irred at the time, da	uusa(s) and monner as ate and place, and due	stated to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	andta D	10	29c. Licen	se number		9d. Date signed (Mont	•
	4		30. Name and address of person who		death (Item 23a) (Type Hophus E		1 0	ltimore	md 2	224
-9	St Regist	ate	31. Date filed (Month, Day, Year) SEP 1 3 200	22. Regist	trar's Gignature	ule				

Please Type or Print in Black Indelible lak. Ensure All Copies Are Legible. amend 1tem 16a per th 8009 9-13-06 vt Department of Health and Mental Hygiene Centificate of Death State of Maryland / 1
Amend Item 2 per dr., G861, Reg. No. 2006 29079 2. Date of Death 09/09/2006 1. Decedent's Name (First, Middle, Last) 3. Time of Death Younger WILLIAM 3:00 PM 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death RIVERVIEW NURSING HOME BALTIMORE COUNTY

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. BALTIMORE 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) XXM 2 F Yrs. 217-03-0677 91 Oct. 22, 1914 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore Overlea- Baltimore County 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21236 USA 4303 Fullerton Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. XXYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 X Married 1 ☐ Yes ŽŽ No White Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Watch Elementary/Secondary (0-12) College (1-4or 5+) 8th grade N/A Repairman Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William H. Younger Marie Julia Gunther 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David W. Younger (Son) 1917 Stevens Drive Edgewood, Md. 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Parkwood Cemetery 9-13-06 Baltimore, Md 21. Signature of Funeral Service Licensee Lassann Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 assakn 23a. Part1. Enter the disea or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial In tare Due to (or as a consequence of): -0 r0 nan Sequentially list conditions, if any, bading to him solate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to (or as a consequence Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other. 1 Yes 2 100 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

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State Registrar

Physician

/Medical

Examiner

Funeral

Director

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Physician /Medical

Examiner

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The law requires that the death certificate be executed

or Attending Physician:

Division of Vital Records, P.O. Box 68760

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Certification:

Medical

with the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

29b. Signature and title of certifier

hukwuma

29c. License number

DUO6 1907

Avenue

29d. Date signed (Month, Day, Year) 919106

21221

Bultimore

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) AUGUST 27 Physician 2006 10:45 AM MAE YOUNG BOYD ALBERTA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S LAUREL CHERRY LANE NURSING HOME If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, APRIL 4 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Days Hours Months 1 □ M 2 🔯 F SURRY, VIRGINIA 1938 Yrs. 224-50-8485 68 **Director** Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c, City, Town or Location 10a. State 10b. County 23a or 28a-f ehow the Medical Exercicer must be notified at 1X Yes 2 □ No HAMPTON VA Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 23664 1569 OLD BUCKROE ROAD death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "neture!', or items Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: BLACK ð 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE HOUSE WIFE 2 yrs ith and Mental Hygie 27 is marked other r traumatic event, in 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Peges 1 and 2 should be file Deportment of Heelih and Mental hy Important: if Item 27 is marked oth any linjury or other traumatic event ORB. Be CATHERINE BROWN ROBERT L. YOUNG SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3017 BRINKLEY ROAD # 102 TEMPLE HILLS, MD 20748 MABILI B. AKINYELE/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State HAMPTON MEMORIAL 9/5/2006 HAMPTON, VIRGINIA 4 □ Donation 5 □ Other (Specify) 21. Signature of Fundral Ser 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Year) tage /Medical Due to (or as a consequence of Nephropathy Examiner ear Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Records, P.O. Box 68760. physicien Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Dav be detached for 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 DUnknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 200 No 1 ☐ Yes 2 No Division of Vital or Attending Physician: 26. Place of Death (Check only one) Medical Certification: To Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 1/Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation death. filled in by the t hours after deat 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a
To the Funerei C forthe Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D51051 August 29,2006 Road, Ellicotl City, MD 21042 ndres 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salazar 900 . Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 3 0 2006 Registrar

ORIGINAL

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			For State Registrar	State of M		artment of Health a ertificate of Death		/giene Reg. No. 20	06 29081
Ī	Physicia /Medic		Decedent's Name (First, Middle, Mae	Last) Bate			2. Date of D Month Augus	Day	Yeer 2006 1-10 A M
	Examin		4a. Fecility Name (If not institution, Doctor's Hospi			4b. City, Town, or Location of Lanham		4c. County	
	Funeral Director		5. Social Security Number 219262701	6. Sex 7. Ag	e (In yrs. last birthday Yrs.		Min. (Month, D	irth	9. Birthplace (State or Foreign Country) Maryland
	permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heatile and Mental Hygiene. Department of Heatile and Mental Hygiene. Important: If learn 27 is marked other then "neture!", or Items 23s or 28s-f show eny Injury or other traumatic event, the Madical Examinar must be notified at once.	Dire	Usual Residence of Decedent	ce Road		10f. Zip Code 20769		10g. Citizen of V	States
2000	hours after de urel', or Items al Exeminar o	d by Funerai	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Novorced	If Yes, Give Year or Dates:	No	Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexicar 1 ☐ Yes 2 ☐ No Specify:		Specify.	втаск
-61212	ed within 72 I rgiene. er then "net t, the Medica	Completed	15. Decedent' (Specify only highest Efementary/Secondary (0-12) 12	Colfege (1-4ors	(Give 5+)	odent's Usual Occupation a kind of work done during mos DO NOT use retired) rement Special		Federa	usiness/Industry
ylalla	should be fill ind Mental Hy is marked oth umatic eveni	To Be	17. Father's Name (First, Middle, L James Eat 19a. Informant's Name/Relationsh	ton	10h Mail	18. Mothe Sele		ght	
ž.	1 and 2 si dealth an om 27 is r ther traur		Marvis Merritt 20a. Method of Disposition			08 Guinevere Ro		ale, Md.	
	t. Pages 1 rtment of H rtant: If Ite njury or oth		1 Burial 2 Cremation 4 Donation 5 Other (Sp	ecify)	Metropol	ematory or other place) Litan Crematory	8/30/06		lria, Virginia
Da	permit. Departr Imports eny Inje		23a. Part1 Enter the disease, or of	1. Kelr	J	22. Name and Address of Facilit Pope Funeral Ho 538 Marlboro	omes, P.A. Pike Fores		Maryland 20747
	Physician /Medical Examiner		shock or heart failure. List of mmediate Cause (Final disease or condition resulting in death)	aDue to (or as	Zespiro	tory Fai	Vr C		Approximate Interval Between Onset and Death
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.O. DOY	To the Hospital or Attending Physicien: The law requires that the death certificate be exwiting 24 hours after death certificate be exwiting 24 hours after death careful certificate has been signed by the ettending physician a completely filled in by the funeral director, page 2 should be deteched for use as the burial completely filled in by the funeral director.	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant al 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Dat Mo	te of delivery nth Day Year
r (ep i	en signed to	þ	Part II. Other significant condition	Failure		underlying cause given in Part I.	1		nbute to the cause of death? 3 Probably 4 Unknown
מים ומ	n: The law re ficete hes be or. page 2 sh	Completed	Congest	ve their	art to	Llure	1 Tes	opsy ormed? 2A No 1	Were autopsy findings available prior to completion of cause of death?
X	hysicie his certi il directo	To Be	25. Was case referred to medicat examiner? 1 Yes 2 No	Hospital: 1 patie		Othor	of Death (Check only irsing Home 5 \subsetence Res		er (Specify)
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: Atter this certificete he completely filled in by the funeral director, page	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could in 4 Heminide determing	ation of be 280 Pface of Ini	28b. Time (Injury)	Work? M 1 Yes 2	No	how injury occurr	er or Rural Route Number,
Š	ospital or pours after anneral Direct y filled in b		29a. Certifier 1 Certifying	building, et	c. (Specify) of my knowledge, dea	th occurred at the time, date an	City or To	own, State) a cause(s) and ma	nner as stated.
	To the Hi within 24 To the Fi completed	Medical	(Check only 2 Medical E	xeminer: On the basis of and manner st	ated.	29c. License number	in occurred at the time		and due to the cause(s)
/	Ta		30. Name and address of person v	no completed cause of c		m DD 6		8/2	215006
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	D 8118 GOOD	dluckRd	hanh	an, mo. 20707

Registrar DHMH 17 Rev 1/2001

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			For	State of Maryland	d / Depa	rtment of	Health and	Mental Hy	giene	2006	29082
2	, 4		1 - State Registrar Amend#'S 20b.2 1. Decedent's Name (First, Middle, Las.	: Oc.PerFH PGC 9-5-(barcer	incate or	Death	2. Date of Dea		2000	3. Time of Death
	Physici			ristine Ball	ard			August	Day 2.9	, 2006	12:46 AM
1	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Deat			County of Death	
		•	Prince George'	s Hospital (Cente	r (Cheverly	7	Pr	ince G	eorge's
	, Funeral		5. Social Security Number 6. Se	7. Age (In yrs. la	st birthday) 53 Yrs.	If Under 1 Year Months Days		_ (Month, Da	h v, Year)	9. Birth	place (State or Foreign
	Director		Usual Residence of Decedent	(J YIS.			Aug.	_p	945 Wa	shington, D.C.
	yland		10a. State 10b. County		, Town or Loc						10d. Inside City Limits
	a-fst	ctor	MD Prince	George's	Car	pitol F	Heights				1XXes 2 □ No
	I within 72 hours after death with the Maryland liene. I then "neturel", or flems 23a or 28a-f show The Macical Expolicer must be notified a	Funeral Director	10e. Street and Number 7716 Willow Hi	ll Drive		10f. Zip Code	785		-	sen of What Cou	ntry?
	ems ems	Iner	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. V	Vas Decedent of Yes, specify Cui	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	- 1	4. Race - Ameri Black, White	
36	or It	by FL	1 Never Married 2 Married	1 ☐ Yes 2 ☐No If Yes, Give		☐ Yes 2X No				Specify: Bla	ack
00	hour fural		3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:	16a. Deced	ent's Usual Occu	pation		16b. Kin	d of Business/Ir	ndustry
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ylai		To	David Kellieb		1			ria Wis			
Maryland 21215-0036	12 12 17		19a. Informant's Name/Relationship (7 Herbert L. Bal		19b. Mailin 77	g Address (<i>Str</i> ee I 6 Will	tand Number or R	ural Route Numbe Drive	er, City or	Town, State, Zi	o Code)
	1 and Healing		20a. Method of Disposition	20b. Pla	ace of Dispos	sition (Name of	leights.	Date	20c. Loc	cation - City or T	own, State
Baltimore,	9 = 5		1 ☐ Burial 2 ②Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State Che	metery, crem capea	ke Cro	matoSep	t 1,200	Sel-	erdale,	MD MD
Ħ	permit. Pa Departmer Important: eny injury			KIVE			ematory ress of Facility He	nry S.	T 7	1	
ä	Depa Impo eny i		Lany M	. Shall	Co	Inc	4925	N.H. H	Burr	oughs	Ave., N.E.
25	A = # 1		23a. Part 1. Enter the disease, or compshock, or heart failure. List only of the product of the composition	plications that caused the death	. Do not ente	er the mode of dy	ring, such as cardia	c or respiratory ai	rrest,		Approximate Interval Between
	Physician		fmmediate Cause (Finat disease or condition	FATAL CAS	RDIAC	ARRH	YTHMIA				Onset and Death
	/Medical		resulting in death)	Due to (or as a consequ				1 .			
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	pe is	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	ence of):						
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687	ificate g physi	edlo		u							
Вох	leath certificat attending phy I for use as the	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar		Ectopic pregnan	01/		2	3d. Date of deliv	
	deati	Physiclan/Medl	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at time of de		Other (specify)				Month	Day Year
P.0	at the de I by the a	Phys	9 🗆 Unknown					00 - Did			
of Vital Records, I	The law requires that the death certifica ate has been signed by the attending ph age 2 should be detached for use as th	by	Part II. Other significant conditions of	ontributing to death but not resu	Ilting in the ur	nderlying cause g	given in Part I.	1000			the cause of death? bably 4 🕱 Unknown
000	law re as be 2 sho	Completed						24a. Was			opsy findings available ompletion of cause of
<u>m</u>		Com						perfo 1 ☐ Yes	rmed?	death? 1 ☐ Yes	
/ita	Physician: Th rthis certificate ral director, pag	Be (25. Was case referred to medical examiner?					eath (Check only o	one)		
of	this at di	5	1 Yes 2 No		ER/Outpatien	1 3 DON		Home 5 Resid			ify)
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Division	or Attendiater death Director: A	flcat	2 Accident investigation 3 Suicide 6 Could not be determined		me, farm, str						al Route Number,
Div	after after f Direct of in by	Certification:	4 Homicide	building, etc. (Specify)	, ·, , ,		City or To	wn, State,)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director; After completely filled in by the fune	Medical C	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best of my knowniner: On the basis of examinat	wledge, death ion and/or inv	occurred at the restigation, in my	time, date and place opinion, death occ	e, and due to the curred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	Jo the within 2 To the comple	₩ W	29b. Signature and title of certifier	//			nse number		29d. Date	e signed (Month	, Day, Year)
	(h)		1	hour		D1	3921		8	7-30-0	06
	(1)		30. Name and address person who	completed cause of death (ftem	23a) (Type,	Print)		j HEVERLY,			
-	WC.		DI CAN LITTLE		OSPITA	L DRIV	E C	HEVERLY	MI	2018	5
m #	Sta Regist		31. Date filed (Month, Day, Year) AUG 3 1 2006	32. Registrar's Signat	ture			/			
	riegist	1	HOO O I LOUI								

State of Maryland / Department of Health and Mental Hygiene 2006 29083 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Vear **Physician** JACK EUGENE BLACK 25, 3:22 p August 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2235 Deer Run Court Huntingtown
If Under 1 Year If Under
Months Days Hours Calvert Birthplace (State or Foreign Country) If Under 24 Hrs 8. Date of Birth (Month, Oay, Year) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Min Months Hours 1 X M 2 □ F 77 Director March 23, 1929 486-32-0073 Missouri Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County er than "natural", or iteme 23s or 28s-f show Ite Medical Examiner must be nutified at 1X Yes 2 □ No Completed by Funeral Director Maryland Prince George's Hyattsville the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 6521 Perry Court death 20784 12. Was Decedent Ever in U.S. Amed Forces? 1 ☑ Yes 2 □ No 1948— Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: White If Yes, Give Year or Dates: 1950 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Private Carpenter permit. Pages 1 and 2 should be file Department of Heath, and Mental Hy, Important: if Item 27 is marked other any injury or other traumatic event, since. traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Richard E. Black Martha Bell Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Barbara Ashby - Daughter 9141 Madison Avenue, North Beach, Maryland 20714 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Fort Lincoln Cemetery Brentwood, Maryland 8/28/2006 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Licenses 4739 Baltimore Ave., Hyattsville, MD 20781 Lette Darch dankling 23a. Part 1. Enter the disease, or complications that caused the death. Bo not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Metastatic Immediate Cause (Final colon (ancer **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) 6month **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): 68760 Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. 1 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ۵ should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 140 24a. Was an 2 No certificate 1 Yes Division of Vital After this certification Hospital or Attending Physician: Son s 25. Was case referred to medical Be 26. Place of Death [Check only one] examiner Other: 2 1 🗌 Yes 2 😉 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🖾 Other (Specify) Residence 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manne of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No hours after death. investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) á 4 | Homicide To the Hospital within 24 hours a To the Funeral C t 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medica 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and ee Anavol, M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sajeev Anaud, M.D. 7343-A Hanover Parkway Green belt, Maryland, 20770. 31. Date filed (Month, Day, Year) State AUG 2 9 2006 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Physician DENNY ROBERT BRITTINGHAM 26 2006 /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner George's Hos Prince George's Cheverly If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) Data of Birth (Month, Day, Year, Birthplace (State or Foreign
 Country) **Funeral** 10 M 2□ F Months None Director Usual Residence of Decedent Peges 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health end Mental Hygiana. 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "naturel", or flams 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 10d. Insida City Limits Bowie 1 ☑ Yes 2 ☐ No Director Prince George's 10e. Street and Numbe 10f. Zip Code 10g. Citizan of What Country? U.S.A. 2103 Arbar Hill Lane 20716 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar in U,S. Armed Forcas? 11 Marital Status 14. Race · Amarican Indian. Black, Whita, atc. 1 ☐ Yas 2 ဩ No If Yas, Give Yaar or Dates: 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) None 0 None 17. Fathar's Name (First, Middla, Last) 18. Mothar's Name (First, Middle, Maiden Sumama) Be Robbin E. Bailey Denny T. Brittingham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Department of Health e important: if item 27 is any injury or other trains Denny T. Brittingham/Father 2103 Aabar Hill Lane Bowie, Maryland 20716 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Crematory 9/28/2006 RIVERDALE, MARYLAND 21. Signatura of Funaral Sarvice Licensee 22. Nama and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failura. List only one cause on each line. Approximata Interval Batwaen Onsat and Death **Physician** Immediata Causa (Final disaasa or condition resulting in death) /Medical xs,39m2 Examiner Dua to (or as a consequence Examine or Attending Physician: The law requiras that tha death certificate be axecuted Sequentially list conditions, if any, leading to immadiata causa. Enter Undarlying Cause (Disease or injury prematunt Physician/Medical that initiated events rasulting in death) Last Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? ere anemia 2 LI No 1 ☐ Yes 2 ☐ NO 1 TYS 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 12 Impatient Other: 4 Nursing Home 5 Rasidance 6 Other (Spacify) 2 No Certification: To 1 ☐ Yes 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work?

Division of Vital Records, P.O. Box 68760, daath. Director: after

Hospitai 24 hours within 24 hor To the Fune completely fi

State Registrar

29b. Signature and title of certifier aura moleted causa of di

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

28d. Describe how injury occurred

oth (Item 23a) (Type, Print)

ENNINGS

3001 31. Data filed (Month, Day, Year)

AUG 2 9 2005

5 ☐ Pending

invastigation

6 ☐ Could not be determined

1 Watural

2 Accident

3 Suicida

29a. Cartifiai

edlcai

4 ☐ Homicide

(Check only one)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

		1	For State Registrar	State of Mar	yland / D	epartme Certifica	nt of H	ealth ar Death	nd Mei	ntal Hygid	ene2	006	291	085
			Decedent's Name (First, Middle,	Last)				-	2.	Date of Death Month	Day	Year	3. Time of	Death
	Physicia	_	Beverly _F	louston	But	ler			Aı		27, 2		3:15	P M
	/Medic Examin		4a. Facility Name (If not institution,			4b. Ci	y, Town, or	Location of I			4c. Cou	nty of Death		
			8100 Connectic	ut Ave. Su:	te 111		evy Cl				Mont	gomer		
	Funeral Director		007-03-8724	6. Sex 7. Age (In yrs. last birtl	mday) If Und Month		If Under 24 Hours	Min.	Date of Birth (Month, Day, ept. 16	, 1920	9. Birth Cou	place (State o intry) ne	r Foreign
	pu 💌 🗀	-	Usual Residence of Decedent 10a. State 10b. County		Oc. City, Town	or Location							10d. Inside Ci	tv Limits
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_	ter d	Funeral	1 ☐ Never Married 2 ☐ Marrie	Armed Forces?		If Yes, s	ecity Cuba	in, Mexican, I	Puerto Ric	an, etc.)	1	Black, White		
3	urs at	by	3 √Widowed 4 Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	21 X No	Specify:			Spe	city: Wh	ite	
215-0036	be filed within 72 hours after death with the Maryland all Hygiene. Ide Hygiene. Ide other then "natural", or Itema 23a or 28a-f ehow other then "natural", or Itema 23a or 28a-f ehow event, the Madical Examiner must be nutified at		15. Decedent	s Education		Decedent's U (Give kind of			of working	1	6b. Kind o	f Business/l	ndustry	
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Ballimore,	Pages 1 and neut of Heal ant: If item ury or other		20a. Method of Disposition 1 ☐ Burial 2 ∑Cremation	3 ☐Removal from State	20b. Place of cemetery Nation				Date	2 2006 Fa		on - City or 1		
를	5 5 5		4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service I		Nacion					oh Gawl				
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	Examiner				c Obstr		D., 1		Diana				3 Year	
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9	ifficat g phy as th	edi												
Вох	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o		3 □Ectopic	prognance	,			23d.	Date of deli	-	
<u> </u>	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at ti		5 Other		<u></u>				Month	Day	Year
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<u>S</u>	death. ctor: A	atic	2 Accident investig	ation		М	1 🗆	Yes 2 □ N	0					
Division of Vital Records,	or Attendate death Director:	Certification:	3 Suicide 6 Could r 4 Homicide determ		y - At home, fai (Specify)	rm, street, fac	tory, office		281	Location (Str City or Town		umber or Ru	rai Route Nun	nber,
Ω	urs at rai D		X											
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifyin (Check only 2 Medical one)	g Physician: To the best of Examiner: On the basis of and manner state	examination and	, death occur d/or investigat	ed at the tir ion, in my d	me, date and opinion, death	occurred	at the time, da	use(s) and te and pla	manner as ce, and due	to the cause(s)
	withir To th	×	29b. Signature and title of certifier				29c. Licens	e number		29			n, Day, Year)	
	4		1 ikus]	Hanse	n M	10	DC134	43			8/	28/2	200	6
1	D		30. Name and address of Terson	who completed cause of de	ath (Item 23a) (Type, Print)								
			Darcy Hansen MI) / 1145 19th	St. NW	#210	Washi	ngton,	DC :	20036				
	Sta		31. Date filed (Month, Day, Year)	32. Registra	's Signature	Acres	!)							
	Regist	rar	AUG 2	9 2006	J. 10°	STATE								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Register MEND#23a(a)perMD8/29/06, HWW, MbCo Certificate of Death 2. Date of Death 3. 2mg 1 8a8 6 1. Decedent's Name (First, Middle, Last) Day ZUD **Physician** Borsellino Francesco 8:15ª 2006 24, August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital
5. Social Security Number 6. Sex 7. Age Olney Montgomery

9. Birthplace (State or Foreign Country) If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthdav) **Funeral** Min. Months Hours 1**X**] M 2□ F 2, Director 577-62-7998 80 Sept. 1925 Italy Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h Count I Hygiene. other than "naturel", or itema 23a or 28a-f show vent, the Medical Examinar count be notified at 1 ☐ Yes 2 No Directo Maryland Montgomery Olney 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20832 USA 16912 Macduff Avenue death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No II Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. Baltimore, Maryland 21215-0036 point. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel; or item any niury or other traumatic event, the Medical Examinations. filed within 72 hours after 1 Never Married 2 Married Il Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 Barber Hair 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Giovanna Di Giovanni John Borsellino 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 16912 Macduff Avenue, Olney, Maryland 20832 Domenica F. Borsellino/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State 20a. Method of Disposition August 28, 2006 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🖾 Other (Specify) Entombment Gate of Heaven Cemetery Silver Spring, Maryland Funeral Service Licenses F22aliceisd Addres Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 Approximate W3CK Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician resulting in death) /Medical Due to (or as a consequence of): Examiner ukction Sequentially let conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed as the burial-transit D205 that initiated events resulting in death) Last and Due to (d attending physician Box 68760 Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 4☐Pregnant at lime of death 5 Other (specify) Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No the detached 9 Unknown 9 Unknown signed by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown peed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? has this certificate 1 Yes 2 No director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Dispatient 2 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 5 Pending investigation 1 Hatural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Momicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a Certifier Medicai 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tifle of certifier

Registrar

State

30. Name and address of

31. Date filed (Month, Day, Year)

0

18/01 Prince Phillip Dr.

who completed cause of death (Item 23a) (Type, Print),

32. Registrar's Signature

2006

			For State	State of Maryland		rtment of H			200	20097
			1. Decedent's Name (First, Middle, Last)		0071	modic of L	<u>Joan,</u>	2. Date of Dea	Reg. No. / /	3. Time of Death
	Physici /Medio		Alua Maria B	ANKS				aug .	23 200	6 0654" M
7	Examin	er	4a. Facility Name (If not institution, give s	treet and number) ie Deltway		4b. City, Town, or	Location of Dea	th	Doeches	
	Funeral		5. Social Security Number 6. Sex	7. Age in yrs. last	birthday)	If Under 1 Year Months Days	If Under 24 Hrs		9	Birthplace (State or Foreign Country)
	Director		212.66.7111	M 2 ∀ F 50	Yrs.	Worth's Day's	Tiours Will	Sept. 23		Macyland
	yland Now		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Loc	ation				10d. Inside City Limits
9	e Mar	Director	MD Doeches	ter Ca	mbr	idge				1 Yes 2 No
2	with th	Dire	1474 Cambridg	e Rolling		10f. Zip Code	21613		10g. Citizen of What	Country?
1	death	Funeral		12. Was Decedent Ever in U.S. Armed Forces?	13. W			Specify Yes or No- to Rican, etc.)	14. Race - A	merican Indian,
36	72 hours after death with the Maryland natural; or Iteme 23a or 28a-f ehow deal Examiner must be nutified at	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☑ ANo If Yes, Give		Tes, specify Cuba ☐ Yes 2 No	Specify:	to ricall, etc.)		Vhite, etc. Blac K
5-0036	72 hours "natural"		3 Widowed 4 Divorced		6a. Deced	ent's Usual Occupa	ation		16b. Kind of Busine	
21215	ithin 72 88. Men "na	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	O life. D	ind of work done of ONOT use retired	1 1/1	orking	1	1-
121	filed within Hygiene. Ither then and, the Ma		17. Father's Name (First, Middle, Last)	//,	ROCES	SINGLIA		me (First, Middle,	Food Tro	CESSING
lan	e should be filed with and Mental Hygiene is marked other the aumatic event, the	To Be	Leonard Lero	y Banks, SR			Lula	Mae -	Sampso	\checkmark
Maryland	s 1 and 2 should be filled within 72 hc If Heelih and Mental Hygiene. Item 27 is marked other than "netun other traumatic event, the Madical		19a, Informant's Name/Relationship (Typ	De, Print)		101	1 Y	2 11	1/1/	e, Zip Code) 21613
σ	s 1 and if Heelth Item 27 other to		Candace Land 20a. Method of Disposition	20b. Place	e of Dispos	ition (Name of	-10ge 1.	De l'Ewar	20c. Location - City	
altimor	Page ent o nt: If ry or		1 ☑ Burial 2 ☐ Cremation 3 ☐ R. 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	1 1	atory or other plac reket Cem		19 29 sate	East New,	Narket Mr.
alti	permit. Pag Depertment Important: any injury once.		21. Signature of Funeral Service License		1 00	Name and Address	a of Espilia	HOME, P.A	4.	,
B	20 E E G		23a Part Enter the disease or compli	cations that caused the death.	51	· Washi	naton St	Cambri	dae /VID	Approximate
	Physician		23a. Park. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final	e cause on each line	0	- 4 C				Interval Between Onset and Death
>	/Medical		disease or condition resulting in death)	Due to (or as a consequen-	nce of):	5/14/	17119			
	Examiner	e	Sequentially list conditions, if any, leading to immediate	. Due to (or as a consequent	Gerop.					
	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events		,					
90,	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (or as a consequent	nce of):					
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ŏ	leath certifica attending ph for use as t	M/M	230. was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de		Ectopic pregnancy	,		23d. Date of	•
O. B	ne deat the att hed for	sicis	in the past 12 months? 1 ☐ Yes P No 9 ☐ Unknown	4 Pregnant at time of death		Other (specify)			Month	Day Year
٥	res that the de igned by the a be detached		Part II. Other significant conditions con	tributing to death but not resultin	ng in the un	derlying cause give	en in Part I.	23e. Did to	bacco use contribut	e to the cause of death?
Records,	v requires been sign should be	ed by						1 🗆 Y	es 2 100 3 [Probably 4 Dunknown
ecc	ne law re has be ge 2 sho	Completed						24a. Was autop	sy prior	a autopsy findings available to completion of cause of
_			25 100						22 No 10	
Vital	G w	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	VOutpatient	3□ DOA Othe		eath <i>Check only o</i>	ne. lence 6 □Other <i>(</i> 3	Specify)
			27. Manner of Death 1 Natural 5 Pending	1	Bb. Time of Injury	28c. Injun Worl		-	ow injury occurred	
Division	Attending r death.	Icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home	a farm stre		Yes 2 □No	28f. Location (S	Street and Number o	r Rural Route Number,
Div	s efter	Certification:	4 ☐ Homicide determined	building, etc. (Specify)	,	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Tow	m, State)	
	To the hospitel or Attent within 24 hours efter deati To the Funeral Director: completely tilled in by the	edical ((Check only & Medical Examir	sician: To the best of my knowle	edge, death	occurred at the timestigation, in my of	ne, date and place pinion, death occ	e, and due to the curred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	othe	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. License	e number		29d. Date signed (M	onth, Day, Year)
	- > - 0		Vargen &	Jem 40		45	1793		8/27/0	26
			30. Name and address of person who co	mpleted cause of death (Item 23	За) (Туре, Р	Print)	3	+ 0	100	MD21613
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	θ.	07 1/	4177	1 Car	18/10/19/1	1 4 216/5
	Regist		AUG 2 8	2006 Marie	B	donde				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** /Medical Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner 3ALTINERE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. HUPKINS 8. Date of Birth (Month, Day, Year) JULY 31, 1 9. Birthplace (State or Foreign Country) D.C. 5. Social Security Number **Funeral** Hours Months 1 ☐ M 2 💆 F 69 1937 214-34-6564 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-fahow the Medical Examiner must be notified at 1 XYes 2 □ No Director OCEAN CITY MARYLAND WORCESTER the 10a, Citizen of What Country? 10f. Zip Code 10e. Street and Number or Itams 23a or 21842 USA 13450 MADISON AVE., #11 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after 2X Married 1 Never Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ð Specify: WHITE 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any Injury or other traumatic avent, the Madia once. Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be MARGARET CONNOR LESLIE P. COX ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) RONALD G. BERGSMITH SR./HUSBAND 13450 MADISON AVE., #11, OCEAN CITY, MD 21842 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 8/26/06 DELMAR, DELAWARE CREMATORY OF DELMARVA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Foneral Service License 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part1. Enter the disease, or complications to travel the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause in each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical **Examiner** Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physicien and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 Yes 2 No Year Day 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ filled in by the funeral director, page 2 should be 2 VIN 3 Probably 4 Unknown 1 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy Yes 25. Was case referred to medical examiner? 26. Place of Death Check only Hospital: 1 Yes 2 N Other 4 Nursing Home 5 Residence 6 Other (Specify) Irrationt Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Matural ate of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation efter death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral [artifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. re and tiple of certifier 29b. Signaty 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

600

Balfmone

30. Name and address of person who ampleted cause of death (Item 23a) (Type, Print)

mopho

istrar's Signature

KINIM J. BIVALACQUA

AUG 2 9 2006

31. Date liled (Month, Day, Year)

		1 - For State Registrar	State of Man		Department of I	Health and I	Mental Hyg	•	
		Decedent's Name (First, Middle, La	st)				2. Date of Dea	ith	3. Time of Death
Physic		Robert Lo	uis Bee	r			Month		06 7.45 AM
/Medi Examii		4a. Facility Name (If not institution, giv			4b. City, Town,	or Location of Deatl		4c. County of t	
LAGIIII	iei	Coastal Hospice	4 4 5 1	Lak	e Salis	hum		Wicon	nico
Funeral		5. Social Security Number 6. S	ex 7. Age (/	n yrs. last bi	rthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	h 9	Birthplace (State or Foreign
Director		079–16–0695	¥DM 2□F 87	7	Yrs. Months Days	Hours Min.	9/95/19	(18 ^{ar)} Ne	ew York
P		Usual Residence of Decedent							
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yidilid X 1X 13-0030 build be filed within 72 hours after death with the Maryland Mental Hygiene. arked other then "naturel", or items 23a or 28a-1 show afte event, the Medical Examinar must be notitled at	by Funeral Director	10e. Street and Number	•		10f. Zip Code 2180	0.1		10g. Citizen of Wha USA	it Country?
ath w	ra E	402 Tony Tank La							
er de	une	11. Maritat Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Decedent of If Yes, specify Cub	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - A	American Indian, White, etc.
s afte	Ϋ́F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1	lavy	1□Yes 2☐No	Specify:		Specify:	white
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id be ental	To Be	Fredrick Maxwell	Beer			Paul	ine Sieb	er	
and Mendand is marked	-	19a. Informant's Name/Relationship (Type, Print)	198	o. Mailing Address (Stree	t and Number or Ru	iral Route Number	r, City or Town, Sta	ite, Zip Code)
		Barbara Whitehea	d/daughter		402 Tony Ta	ank Lane,	Salisbu	ry, MD 2]	1801
Deficilitions, IN permit. Pages 1 end 2 Department of Health a Important: if item 27 is eny injury or other tre once.		20a. Method of Disposition		20b. Place o	of Disposition (Name of ery, crematory or other pla	ace)	Date	20c. Location - Cit	y or Town, State
Deficiency Sermit. Pages Department of mportant: if it ony injury or or		1 ☐ Surial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Jueniovat itom State		Grove Ceme	1 .	/06	Jamaica,	NY
mit. Dartm Sorts / Inju		21 Signature of Poneral Service Licer	nsee	-			Home.Pro	fessional	L-Association
Depa Impo		and A	Dom goon	> CFSF	50I Snow	HIII-Ra.	, Salisb	ury, MD-2	Association 21804
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the			ing, such as cardia	or respiratory arr	rest,	Approximate Interval Between
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tand rus	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p		3 Ectopic pregnanc	у		23d. Date o Month	f delivery Day Year
the at	Physician/Med	1 Yes 2 No	4 Pregnant at tim 9 Unknown	e of death	5 Other (specify)			Worth	Day Tour
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or A after Direc	Certification:	4 ☐ Homicide determined	building, etc. (Specify)	arm, street, factory, office		City or Tow	m, State)	or Hurai Houte Number,
spital purs (ersi (29a. Certifier Certifying Pl	nysician: To the best of n	ny knowleda	e death occurred at the	ime date and place	and due to the o	Called(s) and man	ar as stated
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o the o the omple	₩ W	29b. Signature and title of certifier		,	29c. Licen	se number	2	29d. Date signed (A	Month, Day, Year)
00		(1)205	Cliff	MAM	()	26778	2	8-74	-0L
1000		30. Name and address of person who	completed cause of deat	h (Item 23a)	(Type, Brint)	63 / (2	0-01	
0 11.		David E Col	rell KW	Cun	teltosniu	00 BO	x 1733	Selish.	MO21802
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06-06680 Kevin B. Biser

Please Type or Print in Black Indelible Ink

Kevin B. Biser State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Examiner September 6, 2006 1238 hrs Boyd Kevin Biser 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 6904 Fox Chase Road **New Market** Frederick If Under 24Hrs. 5 Social Security Number 6 Sex If Under 1 Year 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** 7. Age (In vrs. last birthday) oreign Months Days Hours Min Director 213-92-3698 43 Country) Maryland 1X M 28, 1962 2 Yrs Dec. Usual Residence of Decedent 10a State 10b. County 10d Inside City Limits Oc. City. Town or Location 1 Yes 2 X No Maryland Frederick or 28a-f shov New Market Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 6904 Fox Chase Road 21774 U.S.A. items 23a Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? White etc 1 Never Married 2 Married Yes Yes 2 X No specify. White Widowed Divorced If Yes, Give Year 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) and 2 should be filed within 72 I fealth and Mental Hygiene tem 27 is marked other than "r other than the Medical Baltimore, MD 21215-0036 Buyer Home Depot 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) event. Be Boyd Biser Mary Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin L. Biser 9604 Fox Chase Road, New Market, Maryland
le | 20c. Location - City or Town, State 21774 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, Burial 2 X Cremation 3 Removal from State crematory or other place) Donation 5 Other Specify Metropolitan Crematorium 9/09/06 Alexandria, Virginia Signature of Funeral Service bit a see 22 Name and Address of Facility Roll Property Pr 26401 Ridge Road, Damascus, Maryland **Physician** 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Between Onset and /Medical Death Hydrocodone and chlor heniramine intoxication Immediate Cause (Final disease ≒xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the death certificate be executed ian/Medical X UNPENDED AMENDED item#23a,27,28a-f,perME,g860, 10/2/06 TT Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Physic Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? Yes 2 **~** 25 Was case referred to medical Hospital or Attending Physician: 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Other4 DOA Nursing Home 5 Residence 6 Other: Scene 1 V Yes 28a. Date of Injury (Month, Day,Year) Manner of Death 28b. Time of Injury 28d Describe how injury occurred 28c. Injury at Work? Certification: Natural 5 Pending 1 Yes 2 No Fnd 9/6/2006 Fnd 12:29 and Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 6904 Fox Chase Rd New Market, MD (Specify) found at home Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical within 2 To the 1 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 7, 2006 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32 /Registrar's Signature State 2006 SEP 12 1000

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OUNT	ural',	d by	3 ☐ Widowed 4 🎇 Divord	ed	If Yes, Give Year or Da	ites:				Specify:				pecify: Blac	
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Baltimore Mandand	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-1 show apply injury or other traumatic avant, the Medical Examinat must be notified at ance.		19a. Informant's Name/Relation Shelia Countz		ghter)		3 Car			or Hural Ho Balti			own, State, Zip	Code)
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08760) # E =	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	d		or as a conse									
Division of Vital Becords P.O. Box 6	thet the death certificate by the attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		1 Live bi	ome of pregn nth 2 ☐ Fet unt at time of wn	aldeath 3[⊒Ectopic p ⊒ Other (s¢					230	I. Date of delive Month	ory Day Year
U	igned be del		Part If. Dther significant cond										37		ne cause of death?
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Š	ysicie is cent direct	To Be	examiner? 1 Yes 2 No	Hosp	ital:	patient 2	ER/Outpatie	nt 3□ D0	Othe		of Death <i>(Ch</i> sing Home			Other (Specify	4)
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20			30. Name and address of pers	00-)	_		na 23a) (Tyge	Fring N	BL	UV.	, acoi	D SAM	narit	D WL	NOSPITAZ
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State of Maryland / Department of Health and Mental Hygiene

Jaiviii Ciawioid		For State Certificate of Death Registrar	Re	eg. No. 201	16 2909
Physicia Medical Examin		1. Decedent's Name (First, Middle, Last) Calvin Crawford	2. Date of Deat Month August 26		3. Time of Death 2220 hrs
g, den		4a. Facility Name (if not institution, give street and number) Baltimore Washington Medical Center 4b. City, Town, or Location of Death Glenn Burnie		4c. County of Death	<u> </u>
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min	_	th(MM/DD/YYYY) 9 Bir	ın
	Ŀ	578-92-1388 1 M 2 F 38 Yrs. Usual Residence of Decedent	06/13	3/68 Co	untry) DC
id how any ce.		10a. State 10b. County 10c. City, Town or Location Md Anne Arundel Severn			10d Inside City Limits 1 Yes 2 No
the Maryland a or 28a-f show	Director	10e. Street and Number 10f. Zip Code 21144	10	0g. Citizen of What Cour	ntry?
s afte	by Fune	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced of Fyes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's U.S. 13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto I Yes, Specify Cuban, Me	Rican, etc.)	White, etc. Specify: B	can Indian, Black,
15-0036 Filed within 72 hour Hygiene d other than "natt	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 2yrs Crane Driver		Private	ndusiry
	Be		Crawfo	ord	
ore, MD 2' es 1 and 2 should of Health and M If item 27 is ma	۵[19a Informant's Name/Relationship (Type, Print) Tiria Crawford Wife 7924 Canter Ct Set	tural Route Num 7ern , Mo	nber, City or Town, State 3 21144	, Zip Code)
Baltimore, MD 2121 bernit Pages I and 2 should be fi Department of Health and Mental i Important: If item 27 is marked nijury or other traumatic event,		4 Donation 5 Other Specify:	Date 2 / 0 6	20c. Location - City or Brentwood	od, Md.
Baltimo permit Page Department of Important:		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sne 1409 Fairlake Pl			
Physician /Medical Examiner		23a. Part I. Ellter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of):	respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
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Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify) 9 Unknown	ncy	23d. Date of delivery Month	day Year
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n of Vital Recting Physiciau: The After this certificate funeral director, page	o Be	25. Was case referred to medical examiner? 1 Ves 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursin		Residence 6 Other	·
on of Viewending Physicath. or: After this the funeral dir	-1	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 1 Natural 5 Pending 28a. Date of Injury Aug 26, 2006 28b. Time of Injury 28c. Injury at Work? 2100 hrs 1 Yes 2 ✓ No	28d. Describe h Driver auto f	now injury occurred fixed object collision	n
Divisior Hospital or Attent 24 hours after death Funeral Director:	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Local Street	or Town, S	Street and Number or Ru tate) eway Road,Crofto	
To the Hospital within 24 hours To the Funeral completely filled	Medical (29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred a			
	Me	and manner stated. 29b. Signature and title of certifier O.C.M.E.	-	29d. Date signed (Mol August 27, 2006	nth, Day, Year)
	l	30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120	1		
Sta Regist	ite	31 Date filed (Month, Day Year) 2006 32 Registrar's Signature			

			1 - For State Registrar	State	of Maryla	nd / Depa	artmen rtificat			and Me	ental Hyg	iene •g. No.	2006	29	093
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	/Medic Examin		4a. Facility Name (If not institution, gi				4b. City,	Town, or	Location o		August		County of Death	8:30	
	Examin	C1	873 Rudder Way		·			Anna	apoli	s			Anne .	Arunde	1
	Funeral			Sex 125 M 2□ F		s. last birthday)	If Under Months		If Under 2 Hours	Min.	8. Date of Birth (Month, Day	Year)	Cou	place (State of	or Foreign
ij.	Director		010-22-9056 Usual Residence of Decedent	10 M 20 F	76	Yrs.					Oct. 14	, 19	29 Mas	sachus	etts
	land m m		10a. State 10b. County		10c. (City, Town or Lo	cation							0d. Inside C	ity Limits
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	or 28s	Director	10e. Street and Number				10f. Zip	Code			1	0g. Citiz	en of What Cou	ntry?	
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	er de	Funerai	11. Marital Status	Armed F		U.S. 13.	Was Deced If Yes, spec	lent of Hi	spanic Orig n, Mexican	gin? (Spec i, Puerto P	cify Yes or No- Rican, etc.)	1	 Race - Ameri Black, White, 		
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2	filed within 72 hours after death with the Maryland Hygiene ther than "natural", or Iteme 23a or 28a-f ehow the than Madical Examiner must be nutified at		17. Father's Name (First, Middle, Las	5+			Meteo	prole	3	r's Name	(First, Middle,	Maiden 9		Air Fo	rce
and		To Be	Michael Augustu		c						Josephir		,		
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<u>=====================================</u>	siciar certif recto	Be c	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	Inpatient 2	□ ER/Outpatie		Othe	25		(Check only or		TO:- /0		
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Division of Vital	I or Atte after de Directo	Certification;	3 Suicide 6 Could not 4 Homicide determine	286. Plac	e of Injury - A ling, etc. (Spe	t home, farm, st ecify)	reet, factor	, office		2	28f. Location (S City or Tow	treet and n, State)	d Number or Rui	al Route Nun	nber,
	To the Hospital or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer.	edical C	29a. Certifier 1 Certifying (Check only one)	miner: On the									and manner as place, and due		5)
	within To the	Me	29b. Signature and title of certifier	2	10		29	1	number	10	- 2		signed (Month,	Day, Year)	
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			30. Name and address of person wh Ronald Sroka, M.I		34 Vill	age Gre	en, C	roft	on, N	MD 21	114				
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	Funeral		5. Social Security Number	6. Se		7. Age (In yrs.	last birthday)		r 1 Year	If Under 2		B. Date of Bir (Month, Da	th ly, Year)		place (State or Foreign ntry)
	Director		220-01-1981 Usual Residence of Deceder		X''' 2 1	91	Yrs.	<u> </u>			J	uly 1	1915	Mary	yland
	how		10a. State 10b. Co	unty		10c. Ci	ty, Town or Lo	ocation		-					10d. Inside City Limits
	Ba-f	Director		ne Ar	undel			Annap					10- 07	414/1	1 X es 2 □ No
	a or 3		10e. Street and Number 24 Spa View	Ciral	0			101. 21	p Code	1401			10g. Citizen of United		•
	death	nera	11. Marital Status			edent Ever in U	I.S. 13.	Was Dece			in? (Spec	ify Yes or No		lace - Ameri	can Indian,
36	s after	by Funerai	1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Divo		1 🗍 Yes If Yes, Gi Year or D	2 1 No		1 🗆 Yes		Specity:		, , , ,	Spec		nite
21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or Iteme 23e or 28e-f ehow La Mudical Eraini ar must be notified at	ted t	15. Dec	edent's Edi	ucation	74165.	16a. Dece	dent's Usu	al Occupa	ation			16b. Kind of		
215	ithin 7.	Completed	(Specify only h Elementary/Secondary (0-	1	College (1-4or 5+)	life.	DO NOT	ise retired	,	of working	9			
	filed w Hygier other th	Co	17. Father's Name (First, Mic	idle, Last)	5+	<u> </u>	Direc	tor c	of To		r's Name /	First. Middle	State Maiden Sum		aryland
lan	ould be Mental Marked o	To Be	,,		lbert	Crandal	1					lian I			
Maryland	2 should and N le mail		19a. Informant's Name/Rela					ng Addres	s (Street a	and Number	r or Rural	Route Numb	er, City or Tow	vn, State, Zij	code)
	1 end Health em 27 ther tr		Linda Cranda 20a. Method of Disposition	ll Ra	wson/D	-	1351 Place of Dispo			Annar	colis Da		, Arnol 20c. Locatio	-	
nor	Peges nent of I int: If its ury or o		1 Burial 2 Crema:	tion 3 🗆	Removal from	State	cemetery, cre	matory or	other plac	1	8/26/				
Baltimore,	permit. Peges 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 le marked other than "naturel", or Iteme 23a or 28a-f show any injury or other treumatic event, the Medical Exact at must be notified at once.		21. Signature of Funeral Ser			Da	ltimor	2. Name a	nd Addres	ss of Facility	John	М. Та	vlor F	inera	Maryland l Home, Inc.
8	88 = 88		7. Jichel	108	9/1	Ma	14	/ Duk	e of	GLoud	ceste	r St.	Annapo	lis,M	21401
			23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final	e, or comp List only o	ne cause on	caused the dea each line.	th. Do not en	ter the mo	de of dyin	g, such as c	cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	-		rcinoma (or as a conse		ate						-	
П	Examiner		Sequentially list conditions	- 1		ilure t		ve							
	be disi	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1	Due to	(ur as a conse	quence of).								
<u>~</u>	le be executed ysicien and e burial-transit	Examiner	that initiated events resulting in death) Last	1	c. Due to	(or as a conse	quence of):						·		
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x 68	that the death certifica led by the ettending ph detached for use as th	Physician/Med	IF FEMALE:		220 H voc ou	tcome of pregn	2004								
Вох	Jeath c	cian	23b. Was decedent pregnar in the past 12 months? 1 □ Yes 2 □ No	ıt	1□Live I	pirth 2 Fet	al death 3[□Ectopic p □ Other (s						Date of deliv Month	ery Day Year
P. 0.	by the	hysi	9 Unknown		9□ Unkn	own									
	9 <u>6</u>	þ	Part II. Other significant col	nditions co	entributing to d	eath but not re	sulting in the u	ınderlying	cause give	en in Part I.		1	obacco use co Yes 2 No		the cause of death? bably 4 Xunknown
Records,	w requir	Completed										24a. Was			opsy findings available
Re	The lav	mo:										auto perfe 1 ☐ Yes	psy ormed? 2 No	prior to co death? 1 \(\subseteq \text{Yes}	ompletion of cause of
Vital		Bec	25. Was case referred to me examiner?						1.0		of Death	Check only			
5	Phys rthis ral di	5	1 ☐ Yes 2€No 27. Manner of Death		Hospital: 1 28a. Date		ER/Outpatie			4X_Xvur			dence 6 🗆 0		fy)
<u>o</u>	Attending r death. ector: After y the fune	atlon	1 Natural 5 P	ending vestigation	(Mor	nth, Day Year)	Injury	м	28c. Injun Worl 1 □	k? Yes 2 □ N					
Division	To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	Certification:		ould not be etermined	286. Place	of Injury - At I	ome, farm, st	reet, factor	y, office		28		Street and Nu	mber or Rur	al Route Number,
Ω	pltal cours of cours of filled in		29a. Certifier 1 X Cou	A Phylina Phy	eicien: To the	e best of my kn	owledge deal	th occurre	at the tin	ne date and	t place, ar	nd due to the	causo(s) and	m2000/ 25 /	tated
	n 24 ha	edicai	(Check only 2 Mek	fical Exem	iner: On the b	pasis of examin oner stated.	ation and/or in	vestigatio	n, in my o	pinion, death	h occurred	d at the time,	date and plac	e, and due t	to the cause(s)
	To the To the Comp	M	29b. Signature and title of Co	ertifiler					c. Licenso				29d. Date sig		• • • • • • • • • • • • • • • • • • • •
			7 //	1			- 00 \ =		D570	28			August	. 25,20	JU6
1	5		30. Name and address of be Aditya Chopi			se of death (Ite ely Ave			apol	is, Ma	aryla	nd 21	401		
	Sta		31. Date filed (Month, Day,			Registrar's Sign				,	1				
	Regist	rar	AUG.	9 0 24	100		THE PARTY OF THE P								

Registrar

State

31. Date filed (Month, Dav. Year

SEP 2 7 2006

32. Registrar's Signature

	•		1 - For State Registrar	State of Maryl		artment of H		nd Mental Hy	giene Reg. No. 20	06	29096
	Physici /Medic		1. Decedent's Name (First, Middle, Last Mary Elizabeth Cu					2. Date of De Month Sept.	Day	06	3. Time of Death 11:30am M
	Examin		4a. Fecility Name (If not institution, give			4b. City, Town, or			4c. County		
			Harford Memorial 5. Social Security Number 6. Se		rs. last birthday)	Havre d		4 Hrs. 9 Date of Bir	Harfo		lace (State or Foreign
Н	Funeral Director			M 2X□F 90		Months Days	Hours	Min. 08/09/	916	Mari	place (State or Foreign pland
	pu *		Usuel Residence of Decedent 10a, State 10b, County	100	City, Town or L	conting					0d. Inside City Limits
	Aaryla Fehov	ō	MD Harkord		vre de						1 X Yes 2 No
	r 28e-	rect	10e. Street and Number	110	vie ae	10f. Zip Code			10g. Citizen of	What Cour	ntry?
	th with	al D	100 Revolution St	Apt. 411		21078			USA		
	teme	Funeral Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origi n, Mexican,	n? (Specify Yes or No Puerto Rican, etc.))- 14. Rad Bla	ce - Americ	
36	irs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 □Yes 2X No If Yes, Give Year or Dates:		1□Yes 2 No	Specify:		Specif	y: Wh	ite
Š	filed within 72 hours after death with the Maryland Hygiene. sther then "naturel", or Iteme 23a or 28e-f ehow ent, the Medical Examiner must be notified at	ted	15. Decedent's Edu (Specify only highest grad	reation	16a. Dece	dent's Usual Occupa	ation	of working	16b. Kind of B	usiness/In	dustry
2	vithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done of DO NOT use retired	l)	si working	.,		
2	filed w Hygier ther ti	CO	12th 17. Father's Name (First, Middle, Last)		Hom	emaker	18. Mother's	s Name (First, Middle	Home Maiden Suman	ne)	
au	lid be lental ked o ic eve	To Be	John F. Supik					ie M. Ake		,	
ary	shou and M ie mar		19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Maili	ng Address (Street a		or Rural Route Numb		State, Zip	Code)
∑ `	and 2		Frederick H. Cullu					lavre de Gi			
Baltimore, Maryland 21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 ie marked other then "naturel", or Iteme 23a or 28e-f ehow any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F			osition (Name of matory or other place		Date	20c. Location	-	
E	nit. Permer partment ontent injury		4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens					7/06/06		lle,	MV
ä	Dep Find Personal Per		Jaraine M.	Smith-1	Signal	Itchell-Si 123 S. Wa	muth t shinat	uneral Hor ton. Havre	ne, P.A. de Grac	e. MI	21078
			25a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ications that caused the d ne cause on each line.	eath. Do not en						Approximate Interval Between
,	Physician		Immediate Cause (Final disease or condition resulting in death)	. Scha	K						Onset and Death
	/Medical Examiner			Due to (or as a con		100					
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8760,	ate be executed nysicien and he burial-transit		rosaling in doubly East	Due to (or as a con	sequence or):						
687	ificate g phys es the	edic		d							
Box	eath certific attending pl	an/M	230. Was decedent pregnant	23c. If yes, outcome of pre 1☐Live birth 2☐F		DEctopic pregnancy				te of delive	,
P.O. E	The law requires that the death certificate be executed tto has been signed by the attending physicien and bage 2 should be detached for use es the burial-transit	Physician/Medical	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4☐ Pregnant at time of 9☐ Unknown	of death 5[Other (specify)		0072	MC	onth	D <i>a</i> y Year
	s that t	by Ph	Part II. Other significant conditions co	ntributing to death but not	resulting in the u	inderlying cause give	en in Part I.	23e. Did t	obacco use con	tribute to th	ne cause of death?
ğ	w requires that s been signed t should be det							10	Yes 2□No	3 Prob	ably 4 Dunknown
ĕ	a law r has be	Completed						24a. Was	osy	Were auto	psy findings available apletion of cause of
ā	n: The ficete		OS Was assessed to the second to					1 ☐ Yes	2 PNo	death? 1 🗌 Yes	2 No
Ē	s certi	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	lospital:	⊇ ☐ ER/Outpatie	nt 3□ DOA Othe	00	of Death <i>Check only of</i> sing Home 5 ☐ Resi		or (Space	4)
0	ng Phy ter thi neral		27. Mann of Death	28a. Date of Injury (Month, Day Year					how injury occur		
S	Attending Physician: or death. ector: After this certifice by the funeral director,	catle	2 Accident investigation 3 Suicide 6 Could not be			M 10	Yes 2 □ No				
Division of Vital Records,	l or Atten after deat Director:	Certification;	4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	t home, farm, st ecify)	reet, factory, office		28t. Location (City or To	Street and Numb wn, State)	oer or Rura	l Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificete has completely filled in by the funeral director, page 2.	edical C	29a. Certifier 1 Certifying Phy (Check on 2 Medical Exami	sician: To the best of my	knowledge, deat nination and/or in	h occurred at the timivestigation, in my of	ne, date and pinion, death	place, and due to the occurred at the time,	cause(s) and madate and place,	anner as st	ated. the cause(s)
	ro the within : Fo the	Mec	29b. Signature and title of certain	and manner stated.		29c. License			29d. Date signe	d (Month,	Day, Year)
							062		- /	5/06	
	H		30. Name Address of person in a call	PACLL . M	item 23a) (Type,	19 S ()	w. a.v	Ave H	avre I)es (r	ince MD
	Sta		31. Date file 1 (Month, Day, 'ear)	32. Registrar's Si	AT THE PARTY OF		,	20,000 11	2	1078	3
PL	Registr		SEP 1 3 2	UU6 Messas	Ji Ji	porte					
υH	MH 17 Rev 1/20	UUT									

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** William Henry Dale, Sr. September 6, 2006 6:20 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Calvert Memorial Hospital Prince Frederick St. Mary's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**□**M 2□F Yrs. Director 577-26-8791 March 4, 1924 Virginia Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show other traumatic event, the Madical Examiner must be notified at Maryland St. Mary's Mechanics ville 1 ☐ Yes 2 X No Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 30030 Oak Acres Drive items 23a 20659 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 Xes 2 No 194
If Yes, Give Year or Dates: 194 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1941-1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 No Specify: Completed by White 3 Widowed 4 Divorced "natural", 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any injury or other traumatic event, II a Madie one. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Park & Planning Elementary/Secondary (0-12) College (1-4or 5+) P.G. County 10 Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Steaphen H. Dale Ethel G. Hartless 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William H. Dale, Jr./Son 30030 Oak Acres Dr., Mechanicsville, MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Sept. 7 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Brinsfield-Echols Crem. 2006 Charlotte Hall, MD 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer Brinsfield-Echols F.H., P.A. 22. Name and Address of Facility 30195 Three Notch Rd., Charlotte Hall, MD 20622 - MOOO641 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aspiration Pneumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Respiratory Failure, Aute Renal Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Be Completed Congestive Heart Failure 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? Stoge Dementia 2 🗆 No 1 ☐ Yes 2 ☑ No 1 TYes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Yeer) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation after death Director: 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerel [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Dey, Year) D-50653 GYAN C. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chur Uton Deale ROOM Deale 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 0 7 2006 Registrar

Please Type or Print in Black Indelible Ink

chael Dagenhar	1.	State of Maryl For State egistrar	and / Depar <i>Cert</i>	rtment of tificate of	Health and Death	Mental I		Reg. No. 2	006	2909													
Physician edical Examine	/ 1	i. Decedent's Name (First, Middle,Last) MICHAEL L.	DAGENHA				2. Date of Dea Month August 20	Day Yea 6, 2006	00	ne of Death 144 hrs													
i. Ž	4	4a. Facility Name (if not institution, give street and r 303 Rivermont Drive	umber)	4	b. City, Town, or L Waldorf	ocation of Dea		4c. County of Charles															
Funeral Director		5. Social Security Number 6. Sex 242-96-0794 1X M 2 F	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	if Under 24H Hours M	8. Date of Bin. 11-26-	-1969	Foreign	(State or ENTUCKY													
v any	_	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location					10d Inside City Limits 1 Yes 2 X No														
ith the Maryland 23a or 28a-f show notified at once.	ector 1	MARYLAND CHARLES 10e. Street and Number		WALDORF 10f. Zip Code			0g. Citizen of What Country?																
filed within 72 hours after death with the Maryland Hygiene. Hygiene. Hygiene do dother than "natural", or items 23a or 28a-fish of the Medical Examiner must be notified at once the Medical Examiner must be notified at once the Medical Assemble of the Medical Figure 4 or the Medical Figure 4 o	₫ -		tal Status 12. Was Decedent Ever in U. Armed Forces?				Specify Yes or N rto Rican, etc.)	UNITED STATES 14. Race - American Indian, Black, White, etc.															
urs after dea	≥ -	3 Widowed 4 Divorced If Yes, Give Y	1 Yes 2 X No 4 Divorced If Yes, Give Year			specify: on (Give kind o		Specify: WHI's															
5-0036 led within 72 hours after tygiene. other than "natural", the Medical Examiner	ompleted		(1-4 or 5+)	3	ost of working life. I		U.S. GOVERNMENT																
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	To Be C	To Be C	To Be C	17. Father's Name (First, Middle, Last) OLIN CHARLES DAGENHART				18.Mother's Name (First, Middle, Maiden Surname) AKEMI FUJIMO															
MD and 2 sho alth and m 27 is					-1	1		19a. Informant's Name/Relationship (Type, Print) AKEMI HOHENSTEIN - MOTH 20a. Method of Disposition		303 R		DRIVE		mber, City or Town, State, Zip Code) F, MARYLAND 20602 20c. Location - City or Town, State		502							
Baltimore, permit. Pages I an Department of He Important: If ite injury or other tr		1 Burial 2 X Cremation 3 Removal 4 Donation 5 Other Specify:	from State C	rematory or oth	ner place) MATORY		AUGUST 28, 2006	WALD	ORF, MA														
	1	21. Signature of Funeral Service Licensee MOO 23a. Part I. Enter the disease, or complications that	und	HU	NTT FUNE	RAL HON			WALDORI	20604 F, MD													
Physician /Medical Examiner	ŀ	failure. List only one cause on each line. Immediate Cause (Final disease a Contact C	Sunshot Woun	d of Head					Bei	tween Onset and Death													
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50, te be execuysician an	Vedical	UNPENDED AMENDE	s, outcome of pregr	nancy				23d Date of	f delivery														
Box 6876(e death certificate the attending phy ed for use as the t		23b. Was decedent pregnant in the past 12 months?	e birth gnant at time of de	2 Fe	tal death 3 her (Specify)	Ectopic pre	gnancy	Month	Day	Year													
ires that the de signed by the	ŝ	The state of the s	to death but not re	esulting in the u	underlying cause g	iven in Part I.		tobacco use contres 2 V No 3															
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Divisio al or Atten s after deat al Director ed in by th	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Spec	ace of Injury - At he		et, factory, office b	uilding, etc.	or Town	(Street and Numb , State) nont Drive, W		_													
Division of Vital Rec To the Hospital or Attending Physician: The l within 24 hours after death To the Funeral Director: After this certificate occupletely filled in by the funeral director, page	Medical Ce	29a. Certifier 1 Certifying Physician: To the (Gueck only one) Medical Examiner: On the bas	ritifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as with the modern of the cause o																				
To with	Mec	29b. Signature and title of pertifier) Stated.		29c. License			29d. Date sign		ay, Year)													
13 15 I		Name and address of person who completed of Laron Locke MD. Assistant Med	cal Examiner	111 Penr	n Street, Baltin	nore, MD 2	21201																
Sta Registi		31. Date filed (Month, Day, Year) AUG 2 9 2006 32	Figistrar's Signatu	Is A	ale																		

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death F. DELOREDO Month **Physician** CONCEPCION Septem bei 2006 03/5 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** WICOMICO SALISBURY PENINSULA REGIONAL MEDICAL CENTER If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, Year) MAR 24, 1921 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 F 466-23-1190 85 MEXICO Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23a or 28a-1 ehow empt injury or other treumatic event. If a Medical Exact is at must be notified at once. SUSSEX DELAWARE MILTON 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 28435 W. SPRINGSIDE DRIVE 19968 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ऒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 X Married Maryland 21215-0036 1X Yes 2 □ No Specify: Specify: HISPANIC δ 3 ☐ Widowed 4 ☐ Divorced MEXICAN Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PRODUCTION LINE WORKER CANNERY 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FRANCISCO (UNKNOWN) TERESA (UNKNOWN) ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Alymber of Flural Boute Number City of Town State, Zip Code) PO BOX 282, MILTON DE 19968 TOMAS HERRERA (HUSBAND) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State ODD FELLOWS CEMETERY 9-9-06 MILTON, DELAWARE 4 ☐ Donation 5 ☐ Other (Specify) PO BOX 233 21. Signatur of Funeral Service License 22. Name and Address of Facility SHORT FUNERAL SERVICES INC. MILTON, DE 19968 Blorge Monor 23a. Part1. Enter the Isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASCVD **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner FAILURE RENAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Hospital or Attending Physician: The law requires thet the death certificate be executed use as the burial-transit SEVERE that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4☐ Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 2,00 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No this 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After Natural 5 Pending nours after death. neral Director: Af filled in by the fur investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a. To the Funeral D 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9/6/2006 M.1) 30. Name and address of gerson who completed cause of death (Item 23a) (Type, Print) Jan. M.D Babulal . 106 Millord ST#504B Salisbury MD 21804 31. Date filed (Month, Day, Year) 32. Registrar's Signature State front ! Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2006Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** August 31, 2006 10:25 a.m. Elgutis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's St. Mary's Nursing Center Leonardtown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 □ M 2 🔽 F 85 Yrs. 210-26-8938 03/26/1921 Georgia Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow Pages 1 and 2 should be filed within 72 hours after death with the Maryla nant of Health and Mental Hygiene.
and If Health and Mental Hygiene.
and If Health and Medical Hygiene than 'natural', or itams 23a or 28a-f show ury or other traumatic avant, its Medical Examinar mail to incitified. 1 X Yes 2 □ No Completed by Funeral Director St. Mary's Leonardtown 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 20650 USA 21585 Peabody Street Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Bookkeeping 12 /, Bookkeeper 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Vera Olga Balodis Ludwig Balodis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20656 Erika Haggard / Granddaughter P.O. Box 182, Loveville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 9/1/2006 4 □ Donation 5 □ Other (Specify) Brinsfield-Echols Cr. Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle S. Simons M01206 22955 Hollywood Road, Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CAMBOUR SCULAR M SCASE ATHEROCCIONOTIC Physician /Medical Examiner MITTHE XGARS COYOWANY ANTEM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) P.O. in signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, MY PENT ENSION 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 2 DNo certificate 1 ☐ Yes of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 ☐ No 1 🗌 Inpatient 3□ DOA 2 ER/Outpatient 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Medical Certification; Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: , completely filled in by the f 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD D 56096 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASSOCIATES MOLLYWOOD SMAM · GiLL 32. Pagistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink

obert Faison		State of Maryland / Department of Heal For State Certificate of Deat		Hygiene Reg.	No. 200	6 2910
Physician Medical Examine	/	egistrar Decedent's Name (First, Middle, Last) ROBERT FAISON		2. Date of Death)av Year	3. Time of Death 0111 hrs
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Funeral Director		$\begin{array}{cccccccccccccccccccccccccccccccccccc$		Min. SEPT. 2	(MM/DD/YYYY) 9. Birti Foreigr 2 1958 Cou	nplace (State or NORTH CAROLINA
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Baltimore, pemit Pages a Department of He Important: If its injury or other t		4 Donation 5 Other Specify: CHURCH CEMETE 21. Sign; tury of Funeral Service Licensee / 22. Name and	Address of Facility		WILLARD, NO KINS FUNER R, MARYLAND	ORTH CAROLII AL HOME 20785
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Y Wi	ğ		O.C.N.F.		29d. Date signed (Mor	
		30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.		September 4, 20	
CR		Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penr	Street, Baltimore	e, MD 21201		
Sta Registr		31. Date filed (Month, Day, Year) SEP 0 6 2006				

06-06607 Yvette Fenwick

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R		Mary G. Ripple MD.		f Medical Exa				Street,	Baltimo	ore, ME	21201					
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21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene Important: If Item 27 is marked other then "natural", or Iteme 23a or 28a-f ehow envilury or other traumatic event, the Madical Examinating must be notified as once.	Completed by	(Spec	15. Decedent's in the state of	Education rade completed) College (1-4or 5+)	(Give life.	kind of v DO NOT	ual Occupa vork done d use retired) strat	uring most)	of worki	ng		Kind of Bu		vernment	
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ylar	Menta Menta arked attic ev	To B	Charles	Fox						I	illi	ian Mc	Pher	son	21.0		
Maryland	12 sho		19a. Informant's Na				19b. Mailir	ng Addre	ss (Street a	nd Numbe	r or Rura	d Route Nun	nber, City	or Town,	State, Zip	Code)	
Baltimore, I	Pages 1 and ent of Healti nt: If Item 2				☐Removal from		704 K Place of Disponentery, crein te of Hea	sition (N	ame of other place	9) 7	ugus	Sp ri St 31, 2006	20c.	Location -	City or To	own, State	
Balti	permit. Departm Importa eny inju		21. Signature of Fu	neral Service Lic	onsee Ole						lins	Funer	al H	ome I	Inc.	, MD 20901	u
	Physician /Medical		23a. Part1. Enter the shock, or hea transdiate Cause (disease or condition resulting in death)	(Final		aused the dea each line. r Failu		ter the mo	ode of dying	g, such as o	cardiac o	or respiratory	arrest,			Approximate Interval Between Onset and Death	
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P.O. Box 6	death certi le attending ed for use a	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months?		ointh 2 ☐ Feta nant at time of	al death 3[]Ectopic] Other (pregnancy specify)					23d. Dat Mor	e of delive	ery Day Year	
	requires thet the leen signed by th hould be detach	ξ	Part II. Other signif	icant conditions	contributing to d	eath but not re	sulting in the u	nderlying	cause give	n in Part I.						ne cause of death?	
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9	> .9 0	n: To	27. Manner of Deat		28a. Date	Inpatient 2	28b. Time o		28c. Injury Work	4 LI NUI		me 5 🔀 Re 28d. Describ				<i>'</i>)	-
Ö	Attending r death. ector: After y the fune	atio	 1 □Natural 2 □ Accident 	5 Pending investigati	on	th, Day Year)	Injury	М		? ′es 2 □ N	No						
Division	i Pata o	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	d 28e. Place build	of Injury - At hing, etc. (Speci	ify) 					City or 1	Town, Sta	te)		l Route Number,	
	To the Hospital within 24 hours (To the Funeral completely filled	edicai	29a. Certifier (Check only one)	1 ☐ Certifying F 2 ☐ Medical Exa	Physicien: To the saminer: On the band man	best of my kn asis of examin ner stated.	owledge, deat ation and/or in	h occurre vestigatio	d at the tim on, in my op	e, date and inion, deat	d place, a th occurre	and due to the ed at the tim	ne cause(e, date ar	s) and ma nd place, a	nner as st and due to	ated. the cause(s)	
	To the Within To the compli	Me	29b. Signature and	title of certifier	1	1	00	2	9c. License	number			29d. D	ate signed	(Month,	Day, Year)	-
	5)	Slong a	1	Aun	1		D17	368			Aug	gust	28,	2006	
_			30. Name and addr Stanley	A. Schwa			m 23a) (Type, .01 Med		Park	Driv	e, s	Silver	Spr	ing,	MD 2	0901	
	Sta Registr		31. Date filed (Mon	th, Day, Year)	2006 32.	egistrar's Sign	ature	and of	9								

State of Maryland / Department of Health and Mental Hygiene 2006 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day **Physician** August John Henry Foster 21 2006 11 · 45 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Berlin Nursing & Rehabilitation Center Worcester Berlin If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1MM 2□F Months Hours Director Nov. 17, Florida 1928 728-10-3413 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If Item 27 ie marked other then "naturaf", or frema 23a or 28a-f ehow any injury or other treumatic event, Ita Mudical Everyrest must be notified at once. 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Director Maryland Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10218 Ocean City Boulevard 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married KIYes 2 7953-1956 oster, John H. altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9th laborer Gold Coast Mall 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jesse McCray Louise (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Renate & Albert Collick/caregiver 9309 Seabawk Road - Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State MD V.A. Cemetery 08/29/2006 4 ☐ Donation 5 ☐ Other (Specify) Hurlock, Maryland 22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD 21. Signature Funeral Service Licensee JOLLEY MEMORIAL CHAPEL 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** VOUN ear /Medical Due to (or as a consequent Examiner Sequentially list conditions, if any, teating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit ettending physicien end Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: ဥ Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this s after death.
I Director: After this id in by the funeral d 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1- Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, data and plane, and due to the causa(s) and manner as stated, Medical Continued Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature a 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) Cooled Highwa 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar AUG 2 8 2006

06-05920 Richard Frizzell

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Physici		1- For State Certificate of Death Registrar	Reg. No. 2006 29
al Exam			Month Day Year August 10, 2006 0631 hrs
II Exam		ta. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	4c. County of Death
		Peninsula Regional Hospital Salisbury	Wicomico
Funeral	. F		8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or
Director		212-31-6283 1X M 2 F 21 Yrs. Months Days Hours Min.	July 11, 1985 Foreign Country) D.C.
		Usual Residence of Decedent	
w an		10a. State 10b. County 10c. City, Town or Location Maryland Wicomico Salisbury	10d Inside City Li 1 Yes 2 X
death with the Maryland or items 23a or 28a-f sho must be notified at once.	호		
ith the Maryland 23a or 28a-f show any notified at once.	Director	10e. Street and Number 10f. Zip Code	10g Citizen of What Country?
ith the	a D	29180 Naylor Mill Road 11. Marital Status 21801 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spec	USA cify Yes or No- 14 Race - American Indian, 8lack
items	Funeral	1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Ri	
		1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:	Specify White
72 hours after n "natural", o al Examiner i	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation (Give kind of wor	rk done 16b Kind of Business/Industry
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be filed within nial Hygiene rked other tha ent, the Medic			
Mental Hygiene marked other than c event, the Medical	To Be	Jeffrey William Frizzell 19a Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Run	
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permit Page Department of Important: injury or other		21. Sy nature of Funeral Service Livins re 22. Name and Address of Facility 1213	3 Jersey Road - Salisbury, M
T. E. D. B.		JOLLEY MEMORIAL	CHAPEL 218
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Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 29106

1	F	Registrar	ate of Death		Re	g. No	
Physiciar Medical Examin	1/	1. Decedent's Name (First, Middle,Last)			2. Date of Death Month September	Day Year	3. Time of Death 0742 hrs
Endan		FERNANDO C. GUARTE 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Le	ocation of Death		4c. County of Death	
Funeral		Union Memorial Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Baltimore If Under 1 Year	If Under 24Hrs	. 8. Date of Birth	n(MM/DD/YYYY) 9. Birt	hplace (State or
Director		218-80-8021 1X M 2 F 45	Yrs Months Days	Hours Min	_	Foreig	
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er death wi	Fune	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	13. Was Decedent of Hisp If Yes, specify Cuban, 1 Yes 2 XX No	Mexican, Puerto		14. Race - Americ White, etc.	ACK
nours af	g p	15. Decedent's Education (Specify only highest grade completed) 16a. [Decedent's Usual Occupation	on (Give kind of v		16b. Kind of Business/li	
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MD 21215-0036 at 2 should be filed within 7 th and Mental Hygiene n 27 is marked other than numrific event, the Medica	ည် Be	17. Father's Name (First, Middle, Last) ALONSO C. GUART'E			(First, Middle, M FORD	laiden Surname)	
AD 2121(2 should be fill 1 and Mental F 27 is marked matic event, 9		19a. Informant's Name/Relationship (Type, Print)	. Mailing Address (Street	and Number or f	Rural Route Num		Zip Code)
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Baltimore, permit Pages I at Department of Hee Important: If ite		1 Burial 2 Cremation 3 Removal from State RATHER 4 Donation 5 Other Specify:	ory or other place) R FAMILY CEM.	. 09		CREWE, VA.	
	1	21. Signature of Funeral Service Licensee Pullip Bell 8-	22. Name and Address of 914 S. MAIN	N 51., F	ARMVILL	E, VA.	
Physician /Medical		23a. Part I. Enter the divides, or complications that caused the death. Do no failure. List only the cause on each line.	t enter the mode of dying, s	such as cardiac c	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Hepatic Cirrhosis Due to (or as a consequence of):					200
and the same of th	Ĕ	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):					
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Division of Vital Records, P.O. Box 687. To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as t	Physician	past 12 months? 1 Ves 2 No 9 Unknown 1 Live birth 4 Pregnant at time of death 9 Unknown		Ectopic pregna	ancy	Month E	lay Year
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Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	ledical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.					
F.3 F.8	Me	29b. Signature and title of certifier	29c License			29d. Date signed (Mor	
(1)		famely grithall, no	O.C.N	/I. ∟ .		September 2, 20	Ub
26		30. Name and address of person who completed cause of death (Item 23a) Pamela Southall, MD Assistant Medical Examiner	111 Penn Street, Ba	altimore, MD	21201		
Sta Regist	_	31. Date filed (Month, Day, Year) SEP 2006 32. Registrar's Signature	,			·	

06-06619 Alexis N. Gales

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

	F	1- For State Criticate of Death Reg No. 2006 2	910
Physiciar Medical Examin	-	1. Decedent's Name (First, Middle,Last) Alexis Nicole Gales 2. Date of Death Month Day Year September 4, 2006 1005 hrs	ath .
	1	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4d20 Stock Bridge Court Glen Dale Prince George's	
Funeral	- 1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State, Experience, Walshi)	naton
Director	L	219-47-1532 1 M 2KF 10 Yrs. Aug 16, 1996 Country) DC	
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside Ci	
Vlaryland 28a-f show any d at once.	<u>ş </u>	Maryland Prince George's Glen Dale 1 1 X Yes 2 1 1 Oe. Street and Number 10f. Zip Code 10g. Citizen of What Country?	! No
15-0036 filed within 72 hours after death with the Maryland I Hygiene. ed other than "natural", or items 23a or 28a-f sho it the Medical Examiner must be notified at once.	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4420 Stock Bridge Court 20720 USA	
th with the ems 23s		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bla If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.	ck,
fter dea		3 Widowed 4 Divorced of pates: 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No specify: Specify: Specify:	
hours a	ted by	45. Decedents Education (Specific poly highest grade completed). 46a. Decedent's Liquid Occupation (Give kind of work done. 16b. Kind of Rusiness/Industry)	
5-0036 led within 72 hours Hygiens of the than "natur the Medical Exam	Completed	4th Student Government	
21215-0036 Juld be filed within 7 Mental Hygiene, marked other than	S C	17. Father's Name (First, Middle, Last) Michael Gales 18. Mother's Name (First, Middle, Maiden Surname) Karen Phillips	
	৽ঢ়	19a. Informant's Name/Relationship (Type, Print) Karen Phillips Gales (Mother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4420 Stock Bridge Court, Glen Dale, MD 20720	
e, MD I and 2 sho Health and item 27 is	L	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State	
Baltimore, permit. Pages I a Department of He Important: If ite injury or other tr		1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Doyalfon 5 Other Specify: Chesapeake Crematory 9/9/2006 Beltsville, MD	
Baltimor. permit. Pages Department of Important: If injury or other	1	21. Si, all re of Funeral Service Li ansel 22. Name and Address of Facility Rendon/Hale Funeral Home	
Physician		9013 Annapolis Road, Lanham MD 20706 23 Part I. Enter the disease, or omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Listonly one case on each line. Approximate Between Or	
/Medical xaminer	1	Immediate Cause (Final disease or condition resulting in death) Seizure disorder associated with focal bronchiolitis and pneumonia Due to (or as a consequence of):	
park		Sequentially list conditions,	
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	
ecuted and and transit	_ 1	d	
60, ate be exec	Medica	□ AMENDED #23a,27,perME,g861,11/2/06 TT	
5876 srtificate ling phy			/ear
Box 687 e death certifity the attending ged for use as the	Physician	1 Yes 2 ✓ No 9 Unknown 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	
P.O. B es that the di gned by the	by Ph		
cords, P.C. law requires that has been signed 2 should be dete	eted	24a. Was an 24b. Were autopsy findings	available
ecor he law 1 ate has t	Completed	autopsy performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2	No No
Vital Rec	BeC	25. Was case referred to medical examiner? 25. Place or Death (Check only one)	
Division of Vital Records, lat or Attending Physician: The law requirers after death In Director: After this certificate has been sited in by the funeral director, page 2 should be	ျ	1 Ves 2 No 1 inpatient 2 ER/Outpatient 3 DOA 4 invising notice 5 Residence 6 Votrier. Scene	
ttendin death ctor: A	ation	1 X Natural 5 Pending 2 Accident Investigation	
Division pital or Attent ours after death teral Director: filled in by the	Certification:	3 Suicide 6 Could not be determined Coeffy) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or Rural Route Num or Town, State)	ber, City
Division of Vital Records, P.O. Box 68760, vithe Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit			
To the Hos within 24 h	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
		My Mi Mi O.C.M.E. September 5, 2006	
0		30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
St	ate	31. Date filed (Month, Day Year) 32. Registrar's Signature	
Regist	rar	SEP 0 7 2006 Account America	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Physician 6:15 a M Doris Marie Garner 2006 August 28, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Renaissance Gardens at Riderwood Village Montgomery Silver Spring 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 😡 F Yrs Director August 21, 1923 085-12-8336 83 New York Usual Residence of Decedent the Maryland 10c. City, Town or Location cuents in usin 27 is marked other than "natural", or itema 23a or 28a-f show injury og other treumatic sysnt, the Medical Examinar must be notified at 8. 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 🙀 No Silver Spring Maryland Direct Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 3110 Gracefield Road 20904 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. e filed within 72 hours after all Hygiene.
I Hygiene.
other than "natural", or ite 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ White 3€Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Registered Nurse Health Care 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Itsm 27 is marked o John Arthur Trombly Winifred Loretta Ryan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1498 Sheridan Run Court, Herndon, VA 21170 Karen Garner-Wing/ Daughter 20b. Place of Disposition (Name of August 28, 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place)
Metropolitan Crematory t Burial 2 Cremation 3 Removal Irom State 4 □ Donation 5 □ Other (Specify) 2006 Alexandria, Virginia 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 any ole 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between More than 1 Immediate Cause (Final disease or condition Atherosclerotic Heart Disease **Physician** Month resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the tr detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, φ page 2 should be 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed been 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate has 1 ☐ Yes 1 ☐ Yes 2 ☐ No Division of Vital 2√ No To the Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. investigation 2 Accident 6 Could not be determined 28l. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, tarm, street, lactory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of centifier 1004337 28 esta 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date liled (Month, Day, Year) 5008 29 AUG

M.D.

Karen Merritt,



P.O. Box 68760.

MD 20904

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 116 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 7, 10:25P M 2006 Sept. Edward John Gesell /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 19629 Burke Road White Hall Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. May 19, Year) 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 X M 2 □ F Maryland 65 217-40-3739 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location or 28a-f show other traumatic event, the Medical Examiner must be notified at Baltimore White Hall 1 ☐ Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19629 Burke Road 21161 U.S.A. or Items 23a 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates: "natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Industrial Engineer Shipbuilding 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be finent of Health and Mental Healt: If item 27 is marked of Catherine E. Micucci Nelson E. Gesell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19629 Burke Rd., White Hall, MD 21161 Beverly A. Gesell 20b. Place of Disposition (Name of cemetery, crematory or other place)
Yorktowne 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Sept. 12, ö permit. Page Department Important: If any injury or York, PA * 4 □ Donation 5 □ Other (Specify) Cremation Service 2006 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 21. Signature of Funeral Service Licenses once 24 Second St., New Freedom, PA 17349 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Metastatic Immediate Cause (Final Physician ostat disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. attending physiciar Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy ò in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 23e. Did tobacco, use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ page 2 should be 3 Probably 4 Unknown 1 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 1 🗌 Inpatient Certification: To 3 DOA 5 esidence 6 □ Other (Specify) 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death. To the Funeral Director: A investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide To the Hospital filled ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29c. License number 29d. Date signed (Month, Day, Year))~cologist 29b. Signature and title of certifier 9/8/06 D0056919 nes Justo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Donegan MD, 6569 N. Charles ST., Baltimore, MD 21204 31. Date filed (Mortif, Day, Year) 32. Registrar's Signators State 3 2006 Registrar

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 06-06053 Eric Steven Holland

		1- For State Registrar	Cen	tificate of	Death			Reg. No	201	06 29	
* PMysici	an/	Decedent's Name (First, Middle, Last)	-				2. Date of Month	Death Day	Year	3. Time of Death	
dical Exam	iner		lolland, Jr.				Augus	t 15, 200	6	0012 hrs	
		4a. Facility Name (if not institution, give str Prince Georges County Hosp			Cheverly	or Location of	Death		County of De. Prince Geor		
Funeral		Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Y	ear If Under		of Birth (MM/	DD/YYYY) g	Birthplace (State or	
Director			2 F 18	Yrs.	Months D	ays Hours	Min. Sept	. 25,	1987 For	e Gamp Spri Country) Md	.ngs
u).		Usual Residence of Decedent 10a. State 10b. County	10c. City.	Town or Locati	on					10d Inside City Lii	mits
d how a		Maryland Prince Ge		pitol H						1 X Yes 2	
arylan 8a-f sl at onc	cto	10e. Street and Number	0		10f. Zip Code			10g. Citi	zen of What Co		
ith the Maryland 23a or 28a-f show any notified at once.	Director	4703 Pistachio Ln.			207	43		II _T	nited S	tates	
with ms 23. be no		11. Marital Status	2. Was Decedent Ever in U.S		s Decedent of	Hispanic Origin	1? (Specify Yes	r No-	14. Race - Am	erican Indian, Black,	_
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene Tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once	Funeral	1 X Never Married 2 Married					Puerto Rican, etc.)	White, etc	ack	
rs afte ural", miner	þ	3 Widowed 4 Divorced If Y or 15. Decedent's Education (Specify only h	Dates.		Yes 2 X		nd of work done	16h k	Specify: DI		
2 hour	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)			life. DO NOT us		100. 1	Cirid of Dusiries	is/ititudati y	
5-0036 led within 7 Hygiene other than	nple	12		Morts	gage Pr	ocessor		I	rivate		
5-0 led will Hygie other		17. Father's Name (First, Middle, Last)	•				Name (First, Mid				
MD 21215-0 d 2 should be filed w Ith and Mental Hygie n 27 is marked other numatic event, the N	Be	Eric Holland, Sr.	Pile	1.0			la Elze				
D 212 should be and Menta 7 is marke	To	19a Informant's Name/Relationship (Type Tamala Holland/ Mo			•		er or Rural Route			,	
e, MD 1 and 2 shu Health and item 27 is		20a Method of Disposition	20b. P	lace of Dispos	ition (Name of		Capitol Date		Location - City		
MOre Pages 1 tent of H unt: If i		1 XBurial 2 Cremation 3	(CHIOVAI HOITI GIAIC	rematory or oth			0/01/00	06 7		1 261	
Baltimore, permit. Pages I ar Department of Hes Important: If ite		4 Donation 5 Other Specify. 21. Signature of Funeral Service Licensee			ame and Addr	ess of Facility	8/21/20				
Balt permit. Depart Import		(was my	ikel	\$3	exande 38 Mar	r S. Po Iboro P	Pre/For	estvil	lle, Md	. 20747	
Physician		23a. Part I. Enter the disease, or complicate failure. List only one cause on each I		Do not enter th	ne mode of dyli	ng, such as can	diac or respirator	y arrest, sho	ock, or heart	Approximate Inte Between Onset	
/Medical Examiner			Itiple Gunshot Wound						_	Death	
		b	to (or as a consequence of).							
	ner	Sequentially list conditions, If any, leading to immediate Cause. Enter Underlying Cause	to (or as a consequence of):						-	_
	Examiner	(Disease or injury that initiated	to (or as a consequence of):							
760, icate be executed physician and the burial - transit		d									
D, be exe sician	Physician/Medical	UNPENDED	MENDED								
8760, tifficate by ng physic as the bur	n/Me	23b. Was decedent pregnant in the	23c. If yes, outcome of pregn		tal death	3 Ectopic p	regnancy	230	d. Date of deliv Month	ery Day Year	
Sox 687 leath certific e attending 1 for use as the	icia	past 12 months?	Des and the Constitute of the	. 11.	ner (Specify)	ocotopio p	regriation		WOTH!	bay roa	
Box he death of the attended for us	hys		Unknown								
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours affect death. Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director. page 2 should be detached for use as the burial - transit	þ	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	nderlying caus	se given in Part				to the cause of death?	
ords, w require is been sig should bo	Completed						_	Nas an		autopsy findings avail	
in of Vital Records, ing Physician: The law requir After this certificate has been sureral director, page 2 should l	mple	-						autopsy performed?	death'	o completion of cause ?	of
Vital Rec ysician: The his certificate director, page		25. Was case referred to medical			26 PI:	ace of Death (C		es 2 N	0 1	Yes 2 No	1
/ita ysician ys cer yis cer directe	o Be		ottal: 1 Inpatient 2	ER/Outpatient		Other	Nursing Home 5	Reside	ence 6 Ott	ner;	
n of V ding Ph After th funeral	-	27. Manner of Death	28a. Date of Injury (Month, Day Year) Aug 14, 2006	28b. Time of I	njury 28c. li	njury at Work?	28d Desc Subject		ury occurred		
ion trendi leath. tor:	atio	1 Natural 5 Pending 2 Accident Investigation	Aug 14, 2006	2217 hrs	1	Yes 2 V	No Subject	SHOL			
Division pital or Attendir ours after death. reral Director: A	Certification	3 Suicide 6 Could not be determined	28e Place of Injury - At ho		et, factory, offic	e building, etc	or Tov	wn, State)		Rural Route Number, (City
espita hours uneral		4 M Homicide	(Specify) School yard	-		d.t			, Capitol He		
To the Hospital within 24 hours To the Funeral completely filled	Medical	one) Medical Examiner: Or	To the best of my knowledg the basis of examination ar								
To To	Mec	29b. Signature and title of certifier	d manner stated		29c. Lice	ense number	-	29d.	Date signed (A	Month, Day, Year)	
		andoles	110		0.0	C.M.E.		Aug	just 15, 200	06	
	(30. Name and address of person who com		23a)						-	
UL			t Medical Examiner		Street, Ba	ltimore, MD	21201				
S	tate	31. Date filed (Month, Day, Year)	2. Registrar's Signatui	re 🥒		· 					

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink

errick Harrisoi		State of Maryland / Department of Health and Mental 1-For State Certificate of Death Registrar		eg. No. 2006 291
Physic Medical Exam	an/	Decedent's Name (First, Middle,Last)	2. Date of Deat Month August 22	h 3. Time of Death Day Year 2159 hrs
		Derrick Harrison 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of De		4c. County of Death
Funeral		3411 Claire Drive #204 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24	Hrs 8 Date of Birt	Prince George's th(MM/DD/YYYY) 9. Birthplace (State or
Funeral Director			Min	/1962 Foreign CWESh., DC
» any		10a State 10b. County 10c. City, Town or Location		10d Inside City Limits
ne Maryland or 28a-f show fied at once.	ctor	Maryland Prince George's Suit1 10e. Street and Number 10f. Zip Code		1 X Yes 2 No
ith the Maryland 23a or 28a-f she notified at once	al Director	3411 Claire Drive #204 20746 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?		United States
hours after death with the Maryland "natural", or items 23a or 28a-f she Examiner must be notified at once	y Funeral	Armed Forces? Married Armed Forces If Yes, specify Cuban, Mexican, Put	erto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify. Black
hours a inatura Examin	ted by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT use		16b. Kind of Business/Industry
C1 3 -	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12th Manager		Private/Parking
21215-0036 uld be filed within 7 Mental Hygiene marked other than e event, the Medica		17. Father's Name (First, Middle, Last) Unknown	ame (First, Middle, N	Maiden Surname) e Adams
21215 hould be file and Mental H is marked of	To Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number		
ore, MD set and 2 shoot Health and If item 27 is her traumati		Antoinette Newton/Sister 2202 Savannah St 20a Method of Disposition 20b Place of Disposition (Name of cemetery,	. SE #2	01, Wash., DC 20020
Page nent of	Į.	1 XBurial 2 Cremation 3 Removal from State crematory or other place) 4 Departion 5 Other Specify: Ft. Lincoln Cemetery	9/2/2006	Brentwood, MD
Baltí permit Departn Imports		TALL TO THE STATE OF THE STATE		uneral Home Wash DC 20019
Physician /Medical		23a Part Il Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia failure. List only one cause on each line.	ac or respiratory arre	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Multiple Gunshot Wounds Due to (or as a consequence of):		Death
	<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):		
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated		
cuted and transit	I Exa	events resulting in death) Last Due to (or as a consequence or):		
760, icate be executed physician and the burial - transit	Medical	UNPENDED AMENDED		
Box 6876 The death certificate the attending physele for use as the lead	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pre 4 Pregnant at time of death 5 Other (Specify)	egnancy	23d. Date of delivery Month Day Year
that the de ned by the detached f		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I	23e. Did to	bacco use contribute to the cause of death?
s, P.O. irres that the signed by the defacthed	ed by		1 Yes	2 No 3 Probably 4 Unknown
cords aw requ has beer 2 shoul	Completed		24a. Was a autop: perfor	sy prior to completion of cause of
tal Reco cian: The law certificate has		25. Was case referred to medical 26 Place of Death (Che	1 ✓ Yes 2	
Vital ysician this cert	o Be	examiner?		Residence 6 🗸 Other: Scene
Division of Vital Records, P.O. Box 687 the Hospital or Attending Physician: The law requires that the death certific the Funeral Director. After this certificate has been signed by the attending I pholecy filled in by the funeral director, page 2 should be detached for use as it	ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury FOUND: 28b. Time of Injury FOUND: 1 Yes 2 No. 2150 hrs	28d. Describe h Subject shot	low injury occurred
Division Hospital or Attent 24 hours after death Funeral Director: tely filled in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Car	or Town, S	treet and Number or Rural Route Number, City late) Drive, Suitland, MD
	Medical (29a Certifier (Check only cne) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, death occurred at the time, date and place, medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, death occurred at the time, date and death occurred at the time, date		
T. Too	Me	and manner stated. 29b Signature and title of certifier 29c License number		29d Date signed (Month, Day, Year)
(4)		totu aronica-Polloten O.C.M.E.		August 23, 2006
AC		 Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltin 	nore, MD 21201	
	tate	31 Pate filed (Month, Day, Year) 32. Registrar's Signature		
Regis		AUG 3 1 2006 Property original		
0.011=		UNIGHAL		

	* *	\	For Stete Registrer		State of Ma	-	-	nent of F cate of		nd Mei	ntal Hyg	giene Reg. No.	2006	2911	2
	Physici		1. Decedent's Name Fannie		a) Hubbard						Date of Dea Month ug.	Day	2006	3. Time of Death 17:28	М
	/Medic Examin		4a. Facility Name (If				4b.	City, Town, o	r Location of		<u></u>		County of Deat		
			Holy Cros					ilver	•		D (D: 0		fontgom		
	Funeral Director		5. Social Security Nu 578-20-80	038 1	ex 7. Age 7. Age 8	(In yrs. last birt		nths Days	Hours	Min. F	Date of Birth (Month, Day eb. 16	Year) 19	9. Bin 024 Vir	hplace (State or Forei untry) ginia	gn
	/land		Usual Residence of I	10b. County		10c. City, Town	or Location	1						10d. Inside City Limit	ts
	e Mary	ctor	MD	Montgome	ery	Silve	er Spr	ing						1⊠Yes 2□N	10
	vith th	Director	10e. Street and Num				10	f. Zip Code				•	zen of Whal Co	untry?	
	ne 234	Funerai	11513 Mor	uticello	12. Was Decedent 8	ver in U.S.	13. Was I	2090 Decedent of H specify Cubi		in? (Specif	y Yes or No-	US	A 14. Race - Ame	rican Indian,	
936	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 le marked other then "netural", or Iteme 23e or 28e-f ehow each injury or other treumatic event, the Medical Enarthmer must be notified at ORCE.	by Fun	1 Never Marrie	- 11.0	Armed Forces? 1 ☐ Yes 2 ② If Yes, Give Year or Dates:			specify Cub es 2 XNo	an, Mexican, Specify:	Puerto Rid	án, etc.)		Black, Whit	e, etc. Black	
2-0	72 hou	eted		15. Decedent's Ed		16a.	Decedent's	Usual Occup of work done	ation during most	of working		16b. Kir	nd of Business/		
Maryland 21215-0036	d within giene.	Completed by	Elementary/Secon		College (1-4or 5	+)	Drive	OT use retire	d)			Pε	epco		
nd	tal Hy doth	Be	17. Father's Name (F								irst, Middle,		Sumame)		
<u> </u>	hould d Men marke matic	မှ	Arthur Ea	-	Type Print)	19h	Mailing Ad	dress (Street			Vaden		Town, State, 2	Zin Code)	
N N	nd 2 salth an 27 le				on/Daughte:			lontice				,		20902	
Baltimore,	of Her of Her if item or othe		20a. Method of Dispo		Removal from State	20b. Place of cemeter	Disposition y, cremator	(Name of or other place	сө)	Date		_	cation - City or		
ţ	t. Peg tment tant: I		4 □ Donation	5 ☐ Other (Specif)	()	Ft. Li			-				twood,	Md.	
Ba	Depermit Depermition Imported ony Ir		21. Signature	neral Savice Licen	arshall	e		hall der s					DC 200	011	
			shock, or heart	t failure. List only	plications that caused one cause on each lin	the death. Do r	not enter the	mode of dyir	ng, such as c	ardiac or re	espiratory ar	rest,		Approximate Interval Between Onset and Death	
	Physician /Medical	1	Immediate Cause (F disease or condition resulting in death)	-inal	a Metasta	tic Brea		ncer w	ith me	etasta	asis t	o th	ie		
	Examiner		Name and the same of the same			and lung									
	D #	iner	if any, leading to imr cause. Enter Underl Cause (Disease or in	mediate lying	Due to (or as	a consequence of	of):								
	xecute and II-trans	Examiner	that initiated events resulting in death) La		c. Due to (or as a	a consequence of	of):								
68760,	icate be executed physicien and s the burial-transit	edical E		l	d.										
	ntificat ng phy s as th		IF FEMALE:			-									
P.O. Box	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent in the past 12 n 1 Yes 2 3	nonths?	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death		pic pregnancy er (specify)	<i>y</i>			2	3d. Date of del Month	ivery Day Year	
ď	res that igned by be deta	by Ph	Part II. Other signific	cant conditions c	ontributing to death be	at not resulting in	the underly	ring cause giv	en in Part I.		23e. Did to	bacco u	se contribute to	the cause of death?	
ord	w require been signated should b	ted	Hepoxic	encephal	Lopathy						1 □ Y	es 2 🛭	No 3□Pr	obably 4 Unknow	vn
I Records,	The law are has by page 2 st	Completed	*	e							24a. Was a autop perfor	sy med?	24b. Were au prior to death?	topsy findings availab completion of cause of 2 XNo	ole f
Vita	Physician: r this certific ral director,	Be	25. Was case referre		Hospital:			Ott	0.5		Check only o				
ō	Phys or this oral dii	. To	1 ☐ Yes 2 ☒ N 27. Manner of Death	-	28a. Date of Injur		ime of	28c. Injui	4 1401		5 Resid		Other (Spery occurred	cify)	
ion	Attending r death. ector: After by the fune	atio	1 ⊠Natural 2 ☐ Accident	5 Pending investigation		r Year) li	njury M		rk? Yes 2 ☐ N	lo					
Division of Vital	al or Atte s after de al Directo	Certification:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Injubuilding, etc	iry - Al home, fa :. (Specify)	rm, street, f	actory, office		28f	Location (S City or Tow	itreet and m, State)	d Number or Ru	iral Route Number,	
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medicai (29a. Certifier (Check only one)	1⊠ Certifying Ph 2 Medical Exam	ysicien: To the best on niner: On the basis of and manner sta	examination and	death occi	urred at the til ation, in my o	me, date and opinion, death	place, and n occurred	due to the dat the time, d	cause(s) date and	and manner as place, and due	stated. to the cause(s)	
	within To the	Σ	29b. Signature and t	title of certifier	0	10		29c. Licens	e number		- 7		e signed (Mont		
	$\overline{(n)}$		O Nama		-	(D)	Time Division		3343			8	/23/200)6	
R			Ruban,		completed cause of d	Forest (Silver	Spri	ng, MD	. 20	910		
	Sta Registr		31. Date filed (Month	h, Day, Year) 2 9 2006	2. Registra	ar's Signature	book								

		1	•	State of Maryla	nd / Depa	rtment		_	ne 2006	29113
//V	/siciar ledica amine	1	t. Decedent's Name (First, Middle, Last) Lola V. Hemme La facility Name (If not institution, give st		2	4b. City, Te	own or Location of Death	Aug.	Day Year 21 2006 4c. County of Death	3. Time of Death
Fune	eral		5. Social Security Number 6. Sex	AL Medical 7. Age (In yrs	. last birthday)	If Under 1 Months	Year If Under 34 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Ye		place (State or Foreign intry) iknown
B Maryland	lifted at		10a. State 10b. County MD Wicomico		ity, Town or Loc		Salisbury			10d. Inside City Limits 1 XYes 2 No
th with the 23a or 28	ust be no	a D	10e. Street and Number 900 Booth St.			10f. Zip C	21801		Citizen of What Cou	
1215-0036 PULL 1215-0036 Hours after death with the Maryland and than "natural", or Items 23e or 28e-1 ehow	Ezaménakto	<u></u>	11. Marital Status unknown 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in I Armed Forces? 1 □Yes 2 □ No If Yes, Give Year or Dates: unki	1	/as Decede Yes, specif	nt of Hispanic Origin? (Spy Cuban, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - Amer Black, White Specify:	
Fem m EAIN Maryland 21215-0036 A 2 should be filed within 72 hours aft th and Mental Hygiene. It is marked other than "natural", or	the Medical	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0·12) unknown	ation completed) College (1-4or 5+)	16a. Deced (Give k life. D	ent's Usual kind of work O NOT use unkr	done during most of won retired)	king	o. Kind of Business/lunknowr	·
ryland 2 ryland 2 rould be filed	natic event,	lo ge	17. Father's Name (First, Middle, Last) unknown	a Print)	105 44-10	Addes	unkno			in Code)
Lola Y, Hemmerain 2412 4 Baltimore, Maryland 21215-0 permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur	eny injury or other traum once.		19a. Informant's Name/Relationship (Typ Docina Plackwell 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify) 21. Signatury of Funeral Service Licensed	guardian 20b.	1504 Place of Disposemetery, crem Lisbury	River	atory 8/2 Address of Facility T	alisbury, Date 200 2/06 S Chomas Func	MD 21801 Location - City or T Salisbury, eral Home	own, State
Physic /Med Exami persenand halosen and halosen and	ical ner transit	cal Exa	23a. Part VEnter the disease, or complice shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) Sequentially list out dillors, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury than initiated events resulting in death) Last d. d.	Due to (or as a conse	ath. Do not enter ATP Do not enter equence of): Proposition of the control of					Approximate Interval Between Onset and Death
Division of Vital Records, P.O. Box 68' to Attending Physicien: The law requires that the death certificat after this certificate has been signed by the attending phy	ched for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	ic. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3 🗌	Ectopic pre Other (spe			23d. Date of deli Month	very Day Year
ecords, P. law requires that t	20 .	2	Part II. Other significant conditions cont	ributing to death but not re	sulting in the un	derlying ca	use given in Part I.	23e. Did tobad	co use contribute to	3.0
al Reco	, page 2 sho	Completed	HYDERTHYROIDIS	5M				24a. Was an autopsy performer	prior to death?	topsy findings available ompletion of cause of
of Vita hysicien	al director	0	1 Tes 20 No		☐ ER/Outpatien		Other: 4 Nursing H	th (Check only one) ome 5 Residence		ufy)
Division of Vital Rec To the Hospital or Attending Physicien: The law within 24 hours alter death. To the Funerel Director: After this certificate has	in by the funera	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At building, etc. (Spec	28b. Time of Injury home, farm, stre	М	c. Injury at Work? 1	28f. Location (Stree City or Town, S	nt and Number or Ru	ral Route Number,
L he Hospital n 24 hours a	pletely filled	Medical Ce	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examin	ician: To the best of my kier: On the basis of examinand manner stated.	nowledge, death nation and/or inv	occurred a restigation,	t the time, date and place in my opinion, death occu	, and due to the caus rred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
To the within	шоо	Σ	29b. Signature and title of certifier	N.T	MD	2	D-006051		Date signed (Mont)	n, Day, Year)
Re	Stat		30. Name and address of person who cord of the filed (Month, Day Year) 2 4	2006 Regularar's Sig	B EA		N SHIRE DIL	SALISIS	WY MD	21804

			For State Registrar	tate of Maryla	•	artment of H			ene g. No 2006	29114
	Physici		Decedent's Name (First, Middle, Last) HOWARD HEI	OGES HARTMA	N, JR.			2. Date of Death Month August 2		3. Time of Death 6:30 P M
	/Medic Examin		4a. Facility Name (If not institution, give stre Vindobona Nursing Ho				Location of Death Heights		4c. County of Dea	
	Funeral Director		5. Sociat Security Number 6. Sex 11 X M		s. last birthday).	tf Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec 12	9. Bir 9. 1911 Ma	thplace (State or Foreign ountry) aryland
	Maryland	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Frederick	10c. (City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	h with th	al Dire	100. Street and Number 10046 Old National I	Pike		10f. Zip Code 2175	64	10	og. Citizen of What C	ountry?
36	rs after deat I', or items 2	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ♣ No If Yes, Give Year or Dates:	1	Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: Wh	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic svent, Ira Modical Exartificat: and be notified at Once.	Completed	15. Decedent's Educat (Specify only highest grade of Elementary(Secondary (0-12)		(Give	dent's Usual Occupa kind of work done of DO NOT use retired, Oil Compa	luring most of work)	ing	6b. Kind of Business	il Company
land 5	uld be filed v Aental Hygie rked other t tic svent, Ib	To Be Co	17. Father's Name (First, Middle, Last) Howard H. Hartman	, Sr.			18. Mother's Nam	e (First, Middle, M ary King		11 company
	nd 2 should be alth and h		19a. Informant's Name/Relationship (Type, Howard H. Hartman			T			City or Town, State, Sville, Ma	<i>Zip Code)</i> aryland 21754
Baltimore,	Pages 1 a ment of Her ant: if item ury or othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Rem '4 □ Donation 5 □ Other (Specify)	oval from State	. 01 ive	natory or other place t Cemeter	y 9/1/	06 F:	rederick,	Maryland
Balt	permit. Depart import any inj		21. Signaturs Fu na Service Licensee	Jacker	V IŽ	Name and Addres BERT E. D OI NORTH	s of Facility ATLEY & MARKET S	SON FUNE T., FRED	RAL HOMES, ERICK, MD	21 701
	Physician /Medical Examiner	_	23a. Part1. Enter the disease, or complicate shock, or head failure. List only one disease or condition resulting in death) Sequentially list conditions.	pue to (or as a cons	NIAL equence of):	INFARC	TION		Disease	Approximate Interval Between Onset and Death IMMEDIATE MANY YEARS
8760,	cate be executed physicien and the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons						
.O. Box 6	death certifi e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	If yes, outcome of pred 1 Live birth 2 F 4 Pregnant at time of 9 Unknown	etal death 3[Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
<u>α</u>	S LO	by	Part It. Other significant conditions contri	buting to death but not	esulting in the u	nderlying cause give	en in Part I.	1		to the cause of death? Probably 4 Dunknown
of Vital Records,	The law ate has b	Completed						24a. Was ar autopsy perform 1 □ Yes 2	prior to	
f Vita	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)	pital: 1 ☐ Inpatient 2	☐ ER/Outpatier	nt 3 DOA Oth	- 2	th (Check only one one 5 Reside	nce 6 Other (Sp.	ecity)
	ding After fune	atlon: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year	28b. Time o Injury	Worl	/ at k? Yes 2 □ No	28d. Describe ho	w injury occurred	
Division	al or Attendir s efter death. Il Director: Al	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. <i>(Spe</i>	t home, farm, st ecify)	reet, factory, office		28f. Location (Str City or Town	reet and Number or F , State)	Rural Route Number,
	To the Hospital or Attent within 24 hours effer deatl To the Funeral Director: completely filled in by the	edical (29a. Certifier (Check only one) (Check only one)	ian: To the best of my record the basis of exame and manner stated.	knowledge, deat ination and/or in	h occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the ca rred at the time, da	use(s) and manner a ate and place, and du	is stated. le to the cause(s)
)	To the within To the comp	W	29b. Signature and title of certifier	jour Mi		29c. Licens) 16675		MG. 30,	and the same of th
	4		30. Name and address of person who cont	pleted cause of death (I	tem 23a) (Type,	Print) BRU	INSLICK,	MO	21716	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) AUG 3 1 200	32. Figistrar's Si	gnature	book				

			For State Registrar	State of Marylar		urtment of F tificate of			giene 2 () Reg. No.	106	29115
		rt.	1. Decedent's Name (First, Middle,	Last)	-			2. Date of De	ath Day	Year	3. Time of Death
N	Physici /Medic		Douglas Clau	ide Haden, Si	· .			Septem		2006	12:00 p.m.
	Examin		4a. Facility Name (If not institution,				r Location of Dea	ath	4c. County		
		4	21279 Lexwood C			Lexingto		S O Data of Bir		Mary'	
7	Funeral Director	Ú)	,	5. Sex 7. Age (In yrs. 11☑ M 2☐ F	9 Yrs.	Months Days	Hours Mir	. (Month, Da	y, Year)	Coun	
			21,4-52-4273 Usuel Residence of Decedent		9			3-5-19	4/	Mary.	Land
	yłand Jow		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				11	0d. Inside City Limits
	a-f si	ctor	Maryland St. Ma	ry's	Lexi	ngton Pa	rk				1 Yes 2 No
	or 28	Director	10e. Street and Number	-		10f. Zip Code			10g. Citizen of	What Coun	itry?
	23a		21279 Lexwood C	Court, Apt. # 30		2065			Unite		
ဖွ	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or Itama 23e or 28e-f show aumatic event, the Medical Examiner must be notified at	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? d 1 ☐ Yes 2 ☑ No If Yes, Give		Vas Decedent of F f Yes, specify Cub: I□Yes 2X No		Specify Yes or No arto Rican, etc.)	- 14. Rad Bla Specif	ce - Americ ick, White, i	
5-003	ural',	d by	3 ☐ Widowed 4X Divorced	Year or Dates:	_					Wh:	ite
<u>v</u>	72 h	Completed	15. Decedent's (Specify only highest		(Give	lent's Usual Occup kind of work done	during most of w	orking	16b. Kind of B	usiness/Inc	dustry
2	within sne. than	d L	Elementary/Secondary (0-12)	College (1-4or 5+)		00 NOT use retire	•		Descr		Coo Componi
N D	filed v Hygie other f	ပိ	10 17. Father's Name (First, Middle, La	l	Ke	pair Tecl		ame (First, Middle,			Gas Company
au	d be antal	To Be		Haden				Gertrude		ŕ	
Maryland 2121	should be fand Mental Fand Men	F	19a. Informant's Name/Relationship		19b. Mailir	g Address (Street		Rural Route Numbe		, State, Zip	Code)
Σ	nd 2 ilth ar 27 is r trau		Michele Brinsfie	ld/Daughter	2302	Alex Cou	rt, Fore	st Hill,	MD 2105	50	
altimore,	permit. Pages 1 and 2 should b Department of Health and Menta Important: if item 27 is marked any njury or other traumatic a		20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·	Place of Dispo	sition (Name of natory or other place	ca)	Date	20c. Location	- City or To	wn, State
Ê	Page lent o nt: If ry or		1 ☐ Burial 2 🕅 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Hemoval from State		d-Echols		-2006	Charlot	te Hai	11. MD
att	porta porta y nju		21. Signature of Funeral Service 1					rinsfiel			
m	\$ 0 E E G	4 6	Laward N. Brin	stield, Jr. MOO	052 2	2955 Holi	Lywood R	oad, Leon	nardtown	a, MD	20650
			23a. Part1. Enter the disease, or construction shock, or heart failure. List or	omplications that caused the dea		er the mode of dyir	ng, such as cardi	ac or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	("		1 Let	7 Lu	2/75			Onset and Death
0	/Medical	10	resulting in death)	Due to (or as a consec	quence of):	1 1	6 ()	-			
	Examiner		Sequentially list conditions,	b		(
	p #	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):						
	and trans	саш	that initiated events resulting in death) Last	c. Due to (or as a consec	ruance of):						
8760,	cate be executed obysician and the burlal-transit		,	Due to (or as a conser	querice or,						
87	physicate sthe	dical		d		· -					
×	The law requires that the death certificate be executed to has been signed by the ettending physician and tage 2 should be detached for use as the burlal-transit	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn	ancy				23d Da	ate of delive	irv
Вох	etter of for u	Physician/M	in the past 12 months?	1 Live birth 2 ☐ Feta 4 Pregnant at time of		Ectopic pregnancy Other (specify)	1				Day Year
o.	the d y the ached	ysi	1 Yes 2 No 9 Unknown	9□ Unknown		,,					
٠ <u>.</u>	res that the de signed by the e I be detached f	by Pi	Part II. Other significant condition	s contributing to death but not re-	sulting in the u	nderlying cause grv	en in Part I.	23e. Did t	obacco use con	tribute to th	e cause of death?
rds	w require: been sig should bi	q p	Carcinono	1 saw				10	Yes 2□No	31 Tob	ably 4 Unknown
Records,	s bee	Completed	Ceri	1				24a. Was		Were autor	psy findings available
	The lav	E O	Promise	- Animia				autor perfo	rmed?	death?	npletion of cause of
Vital		ø	25. Was case referred to medical	Market			26. Place of D	eath Check only o		100	
>	nding Physician: th. After this certifica funeral director, p	To B	examiner?	Hospital: 1 Inpatient 2] ER/Outpatien	t 3 DOA Oth	er: 4 Nursing	Home 5 Aesi	dence 6 Oth	ner (Specify	1)
0	ng Pt ter th		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injui Wor	y at rk?	28d. Describe	now injury occur	red	
0	endii sath. or: Al	atic	2 Accident investiga	ition			Yes 2 □ No				
Division of	al or Attend after death Director: d in by the	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		nome, farm, str ify)	eet, factory, office		28f. Location (: City or Tou		ber or Rura	l Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	edical (29a. Certifier 1 Certifying (Check only one)	Physician: To the best of my kn xamine. On the basis of examin and manner stated.	owledge, death ation and/or in	occurred at the tile restigation, in my o	me, date and place opinion, death occ	ce, and due to the curred at the time,	cause(s) and m date and place,	anner as st	ated. the cause(s)
)	ompl	Me	29b. Signature and title of certifier	110		29c. Licens	se number		29d. Date signe	ed (Month, i	Day, Year)
)	->-0) / /			110	9917		9/1	:100	P
			30. Name and address of person w	ho completed cause of death (Ite	m 23a) (Type.				1/0	/	
			James C. Boyd,				Califor	nia, Mar	yland 2	0619	
	Sta	te	31. Date filed (Month, Day, Year)	32. Begistrar's Sign							
	Registr	ar	SEP 0 6 2006	Read No.	Land.						

	1	For State	State of Maryla		ertment of H ertificate of L			ene2 U U 5	29116
		Registrar 1. Decedent's Name (First, Middle, Las	t)		71110010 01 1		2. Date of Death		3. Time of Death
Physician		Mary Ruby	Hayes				Aug. 27,	2006 Year	12:03 A M
/Medica Examine		la. Fecility Name (If not institution, give				Location of Death		4c. County of Death	
		Civista Medical (LaPlata,	MD If Under 24 Hrs.	O Data of Birth	Charles	place (State or Fernier
Funeral Director		213-40-7377	9X 7. Age (In yrs	s. last birthday Yrs.	Months Days	Hours Min.	June 15,	Ye 17943 Ma	place (State or Foreign intry) ryland
and **	-	Usuel Residence of Decedent 10a, State 10b, County	10c. C	City, Town or L	ocation				10d. Inside City Limits
ster death with the Maryland after death with the Maryland or items 23s or 28s-f show infine result bicontal Discours	ō	Maryland Charl	es	Wa 1	dorf				1 ☐ Yes 2XXNo
the notified	ပ္	10e, Street and Number			10f. Zip Code		10	g. Citizen of What Cou	intry?
th with	a	10475 Mark Drive			20601			U.S.A.	
g g g	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13	. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
336 Jan Satter Jan Satter	by Fi	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 █ No If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify: W	nite
5-0 72 ho	ted	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Dec	edent's Usual Occup re kind of work done o DO NOT use retired	ation during most of work	ing 1	6b. Kind of Business/l	ndustry
vithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ome Maker	d)		Home Own	ner
12. 12. 12. 12. 13. 13. 13. 13. 13. 13. 13. 13. 13. 13		17. Father's Name (First, Middle, Last)			Olile Plaket	18. Mother's Name	e (First, Middle, M		
Maryland 2: Maryland 2: d 2 should be filed v ith and Mental Hygie Z7 Is marked other t traumatic event, in	To Be	John Kenner Scott				Mary Alv			
Should Me mark	ř	19a. Informant's Name/Relationship (19b. Mai	iling Address (Street			City or Town, State, Z	ip Code)
May Mand 2 and 2 and 2 and 2 learth a m 27 learth at 27 l		Arlene R. William	s/Daughter	1321	Mill Iro	n Road, G	oodview,	VA, 24095	
or Hez	1	20a. Method of Disposition 1 X Burial 2 Cremation 3	20b	. Place of Disp cemetery, cr	position (Name of ematory or other plac	(e)	Date 2	0c. Location - City or	Town, State
imor Pages Trant of I		4 Donation 5 Other (Specify	St.	. Mary	's Ep. Cem	n. 08-31	L-2006	Aquasco, I	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Deperment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic event, the Mydical Exeminer must be notified at page.	1	21. Signature of Funeral Service Licer	see M01391		22. Name and Addre untt Fune 1			d Washingto , Waldorf,	
1,		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de	ath. Do not e	nter the mode of dyin	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	· acute	nyoz	ardial	infance	ton	,	Onset and Death
/Medical		resulting in death)	Due to (or as a cons	equence of):	1				
Examiner	_	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	equence of	, are	ing an	- la		
ted nsit	ulue	cause. Enter Underlying Cause (Disease or injury that initiated events	artes	1	Muro				
18760, icate be executed physicien and is the burial-transit.	Examiner	that initiated events resulting in death) Last	C. Due to (or as a cons	equence of):	. wh.	4			
18760, cate be ex	dical		d Hyper	chy	lestero	lem.	e-		
fiffical ng phy as th	•	IF FEMALE:	76				-		0
Box 6 leath certifii	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pred 1 Live birth 2 F	etal death	B Ectopic pregnancy	у		23d. Date of deli Month	very Day Year
IS, P.O. E	Physician/M	1 ☐ Yes 2 ⊠ No 9 ☐ Unknown	4□ Pregnant at time o 9□ Unknown	ordeath :	5 ☐ Other (specify) _				
that the detact		Part II. Other significant conditions of	contributing to death but not	resulting in the	underlying cause giv	ven in Part I.	23e. Did tob	acco use contribute to	the cause of death?
rds quires n sign	ed by	Hyperteners	, Derbel	es m	elltu	1	1 □ Ye	s 2 ØNo 3 □ Pr	obably 4 Unknown
Division of Vital Records, P.O. or attending Phyeicien: The law requires that the dath after death. Director: After this certificate has been signed by the tin by the funeral director, page 2 should be delached.	Completed	simplered no	osculara	lise	ese		24a. Was ar	24b. Were au	topsy findings available completion of cause of
ital Rec	mo	<i>F</i> - /					perform	ned? death?	2 □ No
Vital Faicien: The certificate	Bec	25. Was case referred to medical examiner?					th Check only one	9)	
Of V Physic this co	2	1 ☐ Yes 2 ② No	Hospital: 1 Inpatient 2		ient 3 🗆 DQA			nce 6 Other (Spec	cify)
On of ding Phy h. After thi funeral	lon:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day Year	28b. Time Injur	y Wo	ry at rk?]Yes 2 □No	28d. Describe no	W anjury occurred	
isio ttendi death. ctor: A y the fu	flcat	3 Suicide 6 Could not b	28e. Place of Injury - A	t home, farm,			28f. Location (Sti	reet and Number or Ru	ural Route Number,
Div	Certification:	4 Homicide	building, etc. (Spe	ecify)			City or Town	o, State)	
	edical (29a. Certifier 1 Certifying Pl (Check only one) 2 Medicaf Exa	hysician: To the best of my miner: On the basis of exam and manner stated.	knowledge, de ination and/or	eath occurred at the transfer investigation, in my	me, date and place, opinion, death occur	, and due to the ca rred at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
o the	Me	29b. Signature and title of certifier		/	29c. Licens		17.00	9d. Date signed (Mont	
- FSF0		1 Janes ni	tefell B	imp	D-0	0008370	6	agust	272006
Casasta		30. Name and address of person who						7	
.DB 6		Paul E. Pritchet	t, MD, 118 La	Grange	Ave., PO	Box 1317,	, LaPlata	a, MD 20646	
Star Registra		31. Date filed (Month, Day, Year) AUG 2 9	2006 32. Histrar's Si	J.	South				

			For State Registrar	State of Mai		partment of ertificate of	Health and M Death		giene Reg. No. 2 1 (16 29117
	Physicia	an	1. Decedent's Name (First, Middle, Las	llister	Hovein	ger, Jr.		2. Date of Dea	Day Ye	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give		пеузти		or Location of Death	8	25 200 4c. County of E	
/	Examin	er	Coastal Hospice	At the	lake	Sal	isbury		Wice	m'.co
	Funeral		Social Security Number 6. S		(in yrs. last birtho	Months Days	r II Under 24 Hrs.	8. Date of Birt (Month, Da		Birthplace (State or Foreign Country)
Ε.	Director		482-28-8328	©M 2□F 83	} Yrs	. Morning out		8/10/19	923	Iowa
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
	Maryl	힏	Maryland Wicomic	00	Salisbu	Э				1 XYes 2 ☐ No
	r 28e	iec	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	t Country?
	th with	E C	820 Little John	Drive		2180)4		USA	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Itsm 27 is marked other then "netural", or itema 23e or 28e-1 show other treumatic event, the Medical Examinar must be Examined.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	ver in U.S. Army	 Was Decedent of If Yes, specify Cu Yes 2 No. 	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Black, V	American Indian, White, etc. White
8	turs!	ed	15. Decedent's Ed	ucation	16a. D	ecedent's Usual Occi	upation		16b. Kind of Busin	
75	within 72 ene. then "ne	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5+) lin	e. DO NOT use retir				
21	e filed within al Hygiene. i other then vent, the Me	E C	12	4	E.	lectrical	Contracto			ustrial
밀	be filed tal Hygid d other svent, I	Be	17. Father's Name (First, Middle, Last)	Hougingor	Cr			Frances	Maiden Sumame)	
yla	should be and Mental marked o	ျှ	Hiram McAllister							A To Codel
, Maryland 21215-0036	and 2 shealth and 127 is m		19a. Informant's Name/Relationship (7 Iris Heysinger/w:]8	320 Little	e John Dr.	, Salisk	oury, MD 2	21804
ore	of He of He If item or oth		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	20b. Place of D cemetery,	isposition (Name of crematory or other pi	lace)	Date	20c. Location - Cit	
ij	Pag tment tent: jury c		4 ☐ Donation 5 ☐ Other (Specify)	Salisb	ıry Cremat		6/06	Salisbury	
Baltimore,	permit. Pages 1 and Department of Health importent: If itsm 27 any injury or other t		Socializated Funeral Service Licen	SOOT POOR	- CFSP	THOTIONAY 501 Snow	"Funeral Hill Rd.	Home Pro , Salisk	ofessiona oury, MD	l Association 21804
			23a. Part1. Enter the disease, or companies shock, or heart failure. List only	plications that caused to one cause on each line	he death. Do not	enter the mode of dy				Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a Metas	atic 1	Bladder	- Can	cer		Oriset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of)					
18	_xaminio.	<u>.</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	consequence of)					
	nsit	nin	Cause (Disease or injury		,					
Ć,	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a	consequence of)					
8760,	ysicia e bur	ical	, ,	d						
9	ntificat ng phy as th		IC FCMALE.							
P.O. Box	at the death certificate be executed by the attending physician and tached for use as the buriat-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregnar 5 ☐ Other (specify)	ncy		23d. Date o Month	
	es this	þ	Part II. Other significant conditions o	ontributing to death but	t not resulting in th	ne underlying cause o	given in Part I.	23e. Did t	*	ite to the cause of death? Probably 4 Unknown
Ö	v requir been si should	eted						04- 145-		
al Records,		Completed						24a. Was autor perfo 1 Yes	osy prio ormed? dea	re autopsy findings available r to completion of cause of th? Yes 2
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			26. Place of Dea			(0
of	Phys r this ral di	7. To	1 Yes No	Hospital: patien	/ 28b. Tin	ne of 28c. In	4 Nursing n		dence 6 Other (Specify)
o	Attending I r death. ector: After by the funer	tion	Natural 5 Pending investigation	(Month, Day	Year) Inju		/ork? □Yes 2□No			
Division	i or Attendation designation of the colors o	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injurbuilding, etc.		, street, lactory, offic	е	28f. Location (: City or Tox	Street and Number (wn, State)	or Rural Route Number,
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	Medical C	29a Certifier (Check only one) Certifying Ph Medical Exam	ysician: To the best of and manner state	examination and/	leath occurred at the or investigation, in my	time, date and place, y opinion, death occur	, and due to the rred at the time,	cause(s) and mann date and place, and	er as stated. I due to the cause(s)
	To the within To the Comple	Me	29b. Signature and title of certifier	N	INAMO	29c. Lice	nse number	78	29d. Date signed (A	Month, Day, Year)
	09/W		30. Name and address of person who	completed cause of de	eath (Item 23a) (Ty	/pe, Print)	1007	- 1	1 111	-06) 21802
	1,		31. Date liled (Month, Day, Year)	32. Registra	Tal HOSPI	u po o	x /135	0211	1 Juil	11102
	St Regist	ate rar	AUG 2.8	2006	es M	book			0	

DHMH 17 Rev 1/2001

ORIGINAL

			. For	State of N	Maryland					ental Hyg	giene 200	5 20118
			Stete Registrar 1. Decedent's Name (First, Middle,	Lanti		Cen	tificate	of Dea	ath	2. Date of Dea	leg. No.	3. Time of Death
	Physicia		Charles	Arnold	Haym	an				Month	25 200	ar F.
}	/Medic Examin		4a Facility Name (If not institution,	, 1.	// /.	, ,	4b. City, To	/ 11	tion of Death	110yes	4c. County of D	
	Funeval		Minsula Regional 5. Social Security Number	6. Sex 7.	Age (In yrs. la:	st birthday)	If Under 1	Year If Ur	DULLY nder 24 Hrs.	8. Date of Birth (Month, Day		Birthplace (State or Foreign
	Funeral Director		218-20-7078	1 X] M 2□F	78	Yrs.	Months	Days Ho	urs Min.	12/21/	1927	Maryland
7	ow III		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	ation					10d. Inside City Limits
	Ba-feh	ctor	Maryland Wicon	nico	Sa	lisbur	-					X Yes 2 No
3	Mith tr	Funeral Directo	10e. Street and Number 611 Tressler	Drive			10f. Zip 0	21801			10g. Citizen of What USA	Country?
	ome 2:	Inera	11. Marital Status	12. Was Decede	nt Ever in U.S	. 13. W	/as Decede Yes, specif	nt of Hispani y Cuban, Me	c Origin? (Spe xican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, W	merican Indian, /hite, etc.
0000	within 72 hours after death with the maryland ene. 1. In hear natural; or iteme 23e or 28e-f show the Modical Examinar meat be notified at the Modical Examinar meat be notified.	by Fu	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 12 Yes 2 [If Yes, Give Year or Date:	Kore		□Yes 2		ecify:			white
รี ก็ ก็	nature		15. Decedent' (Specify only highest			16a. Deced	and of work	done during	most of worki	ng	16b. Kind of Busine	ess/industry
7	e filed within al Hygiene. I other then vent, the Me	Completed	Elementary/Secondary (0-12)	College (1-40	or 5+)		o not use :/oper				Retail P	harmacy
and		To Be Co	17. Father's Name (First, Middle, L Albin A. Hayman							(First, Middle, Larmor	Maiden Sumame)	
Mary	s 1 and 2 should by f Health and Ments ftem 27 is marked other treumatic ex	Ė	19a. Informant's Name/Relationsh Lois Hayman/w								r, City or Town, Stat .sbury, MD	
ט י	of Heal of Heal fitem ?		20a. Method of Disposition 1 Burial 2 Cremation	2 Demousl from Sta	20b. Pla	ice of Dispos metery, crem	sition (Name atory or oth	of er place)	0	Date	20c. Location - City	or Town, State
Бапптог	Pag ment ant: I ury o		4 ☐ Donation 5 ☐ Other (Sp	ecify)	Sali	sbury			8/28/		Salisbury	
Da	Depart Depart Import eny Inj		21. Signatura of Funeral Pervice L	4000	<i>-</i>		501 8	Snow H	ill Rd.	, Salis	sbury, MD	l Association 21804
			231. Party. Enter the disease, or shock, or heart failure. List of	complications that ceus only one cause on each	sed the death h if e.	FAIL	or the mode	of dying, suc	ch as cardiac o	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	hysician /Medical		disease or condition resulting in death)	a. Due to (or	as a conseque				(4 . 4 . 4	40	1	
	Examiner	<u>_</u>	Sequentially list conditions,		20 SCLF as a conseque		CA	RD10 VI	ASCUL	AR L), SEASE	
	cuted	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	с		,						
/60,	te be executed ysicien and ne burial-transit	cal Ex	resulting in death) Last	Due to (or	as a conseque	ence of):						
-	certificate nding physics ase as the			d								
X O	death certificate te attending phys d for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		n 2 ☐ Fetalo	death 3 🗆	Ectopic pre			-	23d. Date of Month	delivery Day Year
	0 00 0	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 □ Pregnan 9 □ Unknowr	t at time of dea	atn 5	Other (spe	спу)				
ds, r	The law requires that the de ite has been signed by the i page 2 should be deteched		Part II. Other significant condition	ns contributing to deat	h but not resul	ting in the un	derlying ca	use given in I	Part I.			e to the cause of death? Probably ' 4 Dunknown
Kecords	law req as beer 2 shou	Completed						_		24a. Was	an Z4b. Were	autopsy findings available to completion of cause of
											2 No 1 1	n? Yes 2□No
Vital	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	atient 2 E	R/Outpatient	3 DO	Othor		n <i>(Check only o</i> me 5 ☐ Resid	ne) dence 6 □Other (5	Specify)
	After	lon: T	27. Manner of Death 1 Natural 5 □ Pending		Injury 2 Day Year)	28b. Time of Injury	28 M	c. Injury at Work?		28d. Describe h	now injury occurred	
Division	al or Attending F efter death, I Director: After d in by the funera	Certification:	2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place of	Injury - At hor , etc. (Specify)			1 ☐ Yes office		28f. Location (S City or Tow	Street and Number o	r Rural Route Number,
_	To the Hospital or within 24 hours effe 7 to the Funaral Dir 7 completely filled in		(Check only 2 Medical E	g Physicien: To the be Examiner: On the basi	est of my know	rledge, death	occurred a	t the time, da	ate and place,	and due to the dred at the time.	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	To the F with n 24 To the F complete	Medical	one) 29b. Signature and title of certifier	and manner	r stated.		-	License num			29d. Date signed (M	
		7	Micholas	(Ogbers	- n	D	4	0345	93	Ы	8-26	- 66
/	VOIX		30. Name and address of person v	who completed cause	of death (Item	23a) (Type, I	Print)	2 e	- //		8-26 no 21	Pow'
100	Sta	te	31. Date filed (Month, Day, Year)	32. Reg	istrar's Signati	ure	3		11 -6	19 1		XC'
10	Registr	ar	AUG 2	8 2006	300000	H. 0	mall	P				

ORIGINAL

		For State	State of Man	/land / Dep	artment of He	ealth and M	lental Hygi	•	
Physici	an	Registrar 1. Decedent's Name (First, Middle,		Ce	rtificate of D	veath	2. Date of Death Month	Day Year	3. Time of Death
/Medic Examin	cal	Hazel Virgi 4a. Facility Name (If not institution, Gilchrist C Hospice Car	give street and number)		4b. City, Town, or I		Sept.	5,2006 4c. County of De Baltin	ath
Funeral Director				n yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept. 8,	9. B 1916 V	irthplace (State or Foreign Country) Lrginia
Aaryland Fehow	ō	Usual Residence of Decedent 10a. State 10b. County MD Balti		oc. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2X No
with the 3a or 28a-	I Director	10e. Street and Number 16600 Cedar		· · ·	10f. Zip Code 21152	2	10	g. Citizen of What (Country?
1215-0036 within 72 hours after death with the Maryland ane. then "natural; or items 23a or 28a-f ehow the Madical Exeminar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Noviced 4 Divorced	12. Was Decedent Eve Armed Forces?		Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2X No	panic Origin? (Spe , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify:	
1215-0 within 72 ho ane. then "nature in Madical in	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+)	(Give	dent's Usual Occupat kind of work done di DO NOT use retired) nemaker	tion uring most of worki	ng 1	6b. Kind of Busines	
yland 2 yland 2 yld be filed Mental Hygi arked other attic event,	To Be C	17. Father's Name (First, Middle, La Thomas Sheet	S			18. Mother's Name Nancy	Sage		
9, Mar end 2 sho lealth and m 27 is m		19a. Informant's Name/Relationship Samuel F. Ha	ll/Son	1660	ng Address (Street ar	Grove 1	Rd., Sp	arks, M	21152
Baltimore, Maryland 21215-0036 permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiane. Important: If tem 27 is marked other then "natural; or items 23a or 28a-f ehow eny injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (8ps 21. Signature of Furieral Service Lie	☐Removal from State	2	rove Unit ct Cemeter	ed Sept y 2006 of Facility J.	J. Harte		MD ortuary,Inc
Physician /Medical		23a. Part1/Enter the disease, or or shoot or heartfailure. List or Immediate Cause/Final disease or condition resulting in death)	a	death. Do not ent	er the mode of dying				Approximate Interval Between Onset and Death
1760, C. Ite be executed Ite be executed Ite be burial-transit	Ical Examiner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co		·				
ords, P.O. Box 6876 requires that the death certificate been signed by the attending physic hould be detached for use as the b	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 12 No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of d	alivery Day Year
Division of Vital Records, P.O. To the Hospital or Attending Physicien: The law requires that the de within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Ď	Part II. Other significant condition	s contributing to death but n	ot resulting in the u	nderlying cause giver	n in Part I.		acco use contribute	to the cause of death? Probably 4 Unknown
Division of Vital Records, or or transfer of the saw requires the same death. Director: After this certificate has been signed in by the funeral director, page 2 should be controlled.	Completed						24a. Was an autopsy perform	ed? prior to death?	autopsy findings available completion of cause of
Vita	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	2 ER/Outpatier	Other	26. Place of Death			ecity) hospice
Vision of Vital Attending Physicien: octor: After this certifica by the funeral director.		27. Manner of Death 1 X Natural 5 Pending 2 Accident investigal	28a. Date of Injury (Month, Day Ye	28b. Time o	28c. Injury : Work?	at 2	28d. Describe how		Nospice
DIVIS oital or Att urs after de ral Direct lled in by t	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	building, etc. (5	Specify)			City or Town,	State)	Rural Route Number,
To the Hospital within 24 hours a To the Funeral to	Medical	29a. Certifier (Check only one) 2 Medical Example 29b. Signature and title of certifier	Physician: To the best of maminer: On the basis of examiner stated	amination and/or in	h occurred at the time vestigation, in my opi	nion, death occurre	ed at the time, dat	use(s) and manner atte and place, and du d. Date signed (Mor	e to the cause(s)
) P. 3 F. 8		Me	arli		De	38303			21204
10		- Fix-	HALLES W	6601	N, Cu	ver (+ BAU	tune no	21204
Sta Registi		31. Date filed (Month, Day, Year) SEP 1 3	2006 32. Degistrar's	Signature	cole				

State of Maryland / Department of Health and Mental Hygiene 006 29120 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Mary K. Jackson 08 25 06 8:35A /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner 6200 Cheverly Park Drive Cheverly
If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Prince Georges 8. Date of Birth (Month, Day, Year) 10 14 14 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 5. Social Security Number 1 ☐ M 2 👿 F Months 91 Director 285-24-9645 Usual Residence of Deced South Carolina the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-f show other treumatic event, the Medical Examiner must be notified at MD 1X Yes 2 No Director Prince Georges Cheverlu 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ŏ 6200 Cheverly Park Drive

12. Was Decedent Ever in U.S. Amed Forces? permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural; or items 23c any njury or other treumatic event, the Medical Examerer research. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 2 XNo 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Education Head Start Teacher 2 yrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Henry Rosabell Jackson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6200 Cheverly Park Drive, Cheverly MD 20785 ce of Disposition (Name of Date 200. Location - City or Town, State Cynthia J. Blair/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Woodlawn Cemetery 09-01-06 Toledo. Ohio 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Fune (al Service Licenses 4217 9th. st. N.w. Washington, A.C. 20011 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, otheart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Ischemic Colitis Weeks /Medical Due to (or as a consequence of) **Examiner** Atherosclerotic Cardiovascular Disease Years Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for u Year Month in the past 12 months? 1 ☐ Yes 2 🕅 No Day 4□ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Alzheimer's Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 24 No certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Certification: To 1 🗌 Yes XXNo 2 ER/Outpatient 3 DOA this Director: After this in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1XXVatural 5 Pending investigation death. 1 Tyes 2 ∏No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the 29d, Date signed (Month, Dav. Year) 29c. License number 29b. Signature and title of certifier DC17577 August 29, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N.W. Washinton, Kober TENNSYLVANIA . Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 9 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** MICHAEL TODD JEFFERSON, SR. AUGUST 23, 2006 4:35A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GILCHRIST HOSPICE TOWSON BALTIMORE 5. Social Security Number Sex XIX M 2□ F If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) NOV. 26, 1960 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 45 Yrs 219 78 9363 MARÝLAND Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 23a or 28a-f show Examiner must be nutified at XXYes 2 □ No Director PRINCE GEORGES MD LANHAM 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code 8415 HAMLIN STREET 20706 UNITED STATES death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or itame 11. Marital Status filed within 72 hours after 1 ☐ Yes XXXNo If Yes, Give Year or Dates: XXNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced "naturel" Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12THMAINTENANCE WORKER PRIVATE other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked of Pages 1 and 2 should be nent of Health and Mental int: If item 27 is marked o RALPH LEON JEFFERSON, SR. LORRAINE PROCTOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANTOINETTE JEFFERSON / SISTER 1919 ALLENDALE COURT HYATTSVILLE, MD 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date XXBurial 2 Cremation 3 Removal from State permit. Page Depertment of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) HARMONY MEMORIAL PARK 08/29/2006 LANDOVER, MD 21. Signature of Funeral Service Licensee 22 MARSHALL S FUNERAL HOME OF MARYLAND, INC. n 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a consequence of) CArdio myo dilated mmth disease or condition resulting in death) /Medical Examiner Saquantiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is its lead of the cause). Due to (or as a consequence of) Examiner attending physicien and for use as the burief-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificete 2 □ No 1 ☐ Yes 2 No 1 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No ٩ ihis After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 ANatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the th within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number and ,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ley 6701 N. Charles St. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 2 9 2006 Registrar

			For State Registrar	State o	f Maryland	-	artment rtificate			and M	ental Hy	giene Reg. No	2006	29122
	Physici /Medic		1. Decedent's Name (First, Middle, HATTIE E. TUTT	Last)							2. Date of De Month AUGUST	Da		3. Time of Death $10:00P^{M}$
	Examir		4a. Facility Name (If not institution,	give street and nur	nber)		4b. City, T	Town, or	Location o	of Death		4c	County of Death	
			SOUTHERN MARYLA					CLIN	TON	24 Hrs.			PRINCE (
	Funeral Director		5. Social Security Number 231 30 0181	5. Sex 1 ☐ M ※※ F	7. Age (In yrs. last 82	Yrs.	If Under Months	Days	Hours	Min.	8. Date of Bir (Month, Da	ay, Year)		place (State or Foreign ntry)
	D.		Usual Residence of Decedent								DEC. 1	1 و	923 VIR	GINIA
	arylan ehow dell	_	10a. State 10b. County		10c. City, To	own or Lo	cation							10d. Inside City Limits XIX Yes 2 □ No
	28a-f	Director	MD PRINCE 10e. Street and Number	GEORGES	CLIN	NTON	1 101 90					40.00		
	death with the Maryland ms 23a or 28a-f ehow rmat be notified at		9106 PINEVIEW 1	ANE			10f. Zip						tizen of What Cou	
	death	Funerai	11. Marital Status	12. Was Dece	edent Ever in U.S.	13.		0735 ent of His		gin? (Spe	ocify Yes or No Rican, etc.)		NITED STA 14. Race - Ameri	
٥	or ite		1 Never Married 2 Marrie	Armed For d 1 Tes If Yes, Giv	XX No		ifYes, speci 1 □ Yes Xo		n, Mexican Specify:	, Puerto	Rican, etc.)		Black, White,	
5-0036	n 72 hours after death with the Marylan "naturel; or Items 23s or 28s-f ehow adical Exercinal must be notified at	d by	3 ☐ Widowed 4XX Pivorced	Year or Da	ates:							:	Specify: BLAC	
	n 72 in 72 in at	iete	15. Decedent's (Specify only highest	grade completed)		(Give	dent's Usual kind of worl DO NOT use	k done d	urina most	of workii	ng	16b. K	(ind of Business/In	dustry
1212	d within plane. r then "	Completed	Elementary/Secondary (0-12) 8TH	College (1	-4or 5+)		GIVER					PR	RIVATE	
9	be filed tal Hygi d other event, I	Be C	17. Father's Name (First, Middle, Li	ast)					18. Mothe	r's Name	(First, Middle			
ylan	_ C .	2	UNKNOWN						CASS	SIE V	VATSON			
Mar	nd 2 sh alth and 27 is m ir treum	54	19a. Informant's Name/Relationshi									_	or Town, State, Zij	
	E E E		RENEE WILHITE , 20a. Method of Disposition	/ DAUGHTE			CORNI. sition (Naminatory or other				FT. WA		NGTON, MI	
ē	mit. Pages sertment of sortant: If it injury or o		XIX Burial 2 Cremation 3		State				1	10/21	/2006			
altimore	글 문란를		21. Signature of Funeral Service Li		0 0 0	22	Name and	Address	of Facility	v			SUITLAND,	
n	Depe Impo		117.	11/ we	LUL		MAKSH. 4308				HOME SUIT	LAND	MARYLAND, MD 207	1NC.
	Physician physician executed /Medical Examiner physician end physician end physician end physician end physician end physician executed physician	ical Examiner	23a Part1. End the disease, or c shock, theart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to line additionable cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence	ce of):								Interval Between Onset and Death
. Box 6	deeth certific e ettending p id for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1☐Live bi	come of pregnancy irth 2 □ Fetal dec ant at time of death own	ath 3	Ectopic pre						23d. Date of delive	ery Day Year
<u>ທ</u> ົ	taw requires that the de as been signed by the E 2 should be detached f	þ	Part II. Other significant condition						/	L			-	he cause of death?
cords,	w require been sig should b	eted	Acute hendita	ilian	and and	70 !	Sush	uc v	y ru	mille	·			pably 4 □Unknown
Ĩ	he tay e has	Completed	name in action	1 400 -								psy ormed?	prior to co death?	ppsy findings available mpletion of cause of
<u>ra</u>	ian: 7 rtificet tor. pr	a	25. Was case referred to medical			_			26. Place	of Death	Check only		1 Tes	20 No
0 10	Physician: this certific ral director,	To B	examiner? 1 Yes 2 No	Hospital: 1 🖼	npatient 2 ER/	Outpatien	t 3 DO	Othe	c				6 □Other (Specif	(y)
VISION	ding h. After fune	ation:	27. Mann of Death Natural 5 ☐ Pending 2 ☐ Accident investiga		of Injury h, Day Year)	b. Time of Injury	28 M	C. Injury Work 1 Y	at ? es 2□N		8d. Describe	how inju	ry occurred	
SINIC		ertification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	209. Place	of Injury - At home, ng, etc. (Specify)	, farm, str	eet, factory,	office		2	28f. Location (City or To		nd Number or Rura e)	al Route Number,
	To the Hospital or Attenwithin 24 hours effer deati To the Funeral Director: completely filled in by the	edicai C	29a. Certifier (Check only one)	Physician: To the xaminer: On the ba and mann	asis of examination	dge, death and/or in	occurred a vestigation, i	t the time	e, date and inion, deat	d place, a h occurre	and due to the ed at the time,	cause(s)) and manner as s d place, and due to	tated. o the cause(s)
	To the He within 24 To the Fu	Me	29b. Signature and Wie of ceratier	-				License					te signed (Month,	
			> Kalm	- MD			D	000	551	120		Aus	28 200	4
R	(3)		30. Name and address of person w	ho completed caus	e of death (Item 23:	a) (Type,	Print)	_	_ ~ `		1.	0	28 200 DC2003	-
			KichARD Palmer M		outhen Pagistrar's Signature	wen	ne SE	Sui	TC SI O	W	phingl	ソハ	DC2003	2
	Sta Registr		AUG 2 9 200	_ (w St st	bed	e e				V			

			1 - For State Registrar		aryland / Dep <i>Ce</i>	artment of I			Reg. No. ZUU	29123
	Physici	an	Decedent's Name (First, Middle, L TM					2. Date of Dea Month AUGUST		3. Time of Death 7:58P M
	/Medic		DUK IM 4a. Facility Name (If not institution, g	KIM ive street and number)		4b. City, Town, o	or Location of Dea		4c. County of Dea	
	Lxaiiii	ici	MONTGOMERY G		SPITAL	O	LNEY		MONTGO	
	Funeral Director		5. Social Security Number 6. 227 27 1984 Usual Residence of Decedent	Sex 7. Age 1	(In yrs. last birthday 8 Yrs.	If Under 1 Year Months Days		. (Month, Da	9. Bi y, Year) 9. Bi	rthplace (State or Foreign country) KOREA
	yland		10a. State 10b. County		10c. City, Town or L	ocation				10d. fnside City Limits
	Ba-f sl	ctor	MD MONTG	OMERY	ROCKVIL	LE				1 XYes 2 No
	be filed within 72 hours after death with the Maryland tial Hygiene. do other then "neturel", or Itama 23e or 28e-f show event, Ira Modicel Exertical returnal be notified at	Funeral Director	10e. Street and Number 4011 RANDOL	PH RD		10f. Zip Code	20902		10g. Citizen of What C	country?
	death ma 23	neral	11. Marital Status	12. Was Decedent E	Ever in U.S. 13.	Was Decedent of I		Specify Yes or No-		
ထ္ထ	or Its		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give	lo	If Yes, specify Cub 1 ☐ Yes 2 ☑ No		rto Rican, etc.)	Black, Wh Specify: A	
Ö	hours tural',	ed by	3√Widowed 4 Divorced 15. Decedent's	Year or Dates:	16a Dace					
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Maryland 21215-0036	should be filed within the Mental Hygiene. marked other then matic event, Ine Mi	Be	17. Father's Name (First, Middle, Las	st)			18. Mother's Na		Maiden Surname)	
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	is 1 and 2 should by Health and Men Itam 27 is marke other traumatic		JUNG HEE KIM						TOW VA 2	
altimore,	of He		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3	Removal from State	20b. Place of Disp cemetery, cre	osition (Name of matory or other pla	ce)	Date	20c. Location - City o	r Town, State
Ē	tment of tant: If it		4 Donation 5 Other Spec	cify)	FAIRFAX					
Ba	permit. Pages Department of Important: If It any Injury or o		21. Signatu of Fun rat Style Lic	18	1		YAK DR	UPPER M	ARLBORO I	NERAL SERV MD 20772
E			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused y one cause on each lin	the death. Do not en	ter the mode of dyi	ng, such as cardia	ic or respiratory ar	rest,	Approximate Interval Between Onset and Death
1.5%	Physician /Medical*		frmmediate Cause (Final disease or condition resulting in death)	a. Kes	consequence	tailu	re			Iday
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, je	P #	Iner	Sequentially list conditions, if any, backing to immediate cause. Enter Underlying Cause (Disease or injury		consequence of):					
_	xecute and Il-trans	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	L consequence of):					
8760	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical E		- d						
9	rtificate ng phy as the	Medic	VE 55144 5	U.						
Box	eath certific attending p	Physician/Med	fF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. ff yes, outcome of 1 ☐ Live birth		☐Ectopic pregnanc	у		23d. Date of de Month	olivery Day Year
	he dec	ysic	1 Yes 2 No	4□Pregnant at t 9□ Unknown	time of death 5[Other (specify)			MOILLI	Day 16a
P.0	res that the de signed by the a be detached f	by Ph	Part If. Other significant conditions	contributing to death bu	t not resulting in the u	ınderlying cause gıv	ven in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
rds	w requires been sign should be		Deme	ntia				1 🗆 Y	′es 2 □ No 3 □ P	robably 4 Donknown
ဝင္ပ	law re as bea	Completed						24a. Was a		utopsy findings available completion of cause of
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Division of	Attending Physician: r death. ector: After this certifici by the funeral director.	⊢ .	27. Manner of Death	1 ☐ Inpatier 28a. Date of Injury (Month, Day		II 3LI DOX	4 🗀 Nursing i		lence 6 Other (Speciow injury occurred	ecify)
ioi	ending Paath. or: After he funer	atlo	1 Adural 5 Pending 2 Accident investigate	on	Year) Injury		rk? Yes 2 □No			
Š	il or Attendati after deati Director:	ertiflcatlon:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ry - At home, farm, st . (Specify)	reet, factory, office		28f. Location (S City or Tow	itreet and Number or R n, State)	lural Route Number.
_	To the Hospital or within 24 hours afte To the Funeral Direction Completely filled in I	O	29a. Certifier 1 Certifying F	Physician: To the best o	f my knowledge deat	h occurred at the til	me, date and plan	a, and due to the o	Pause(s) and manner a	s stated
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	(Check only 2 Medical Exa	aminer: On the basis of and manner stat	examination and/or ir	vestigation, in my o	opinion, death occ	urred at the time, o	date and place, and du	e to the cause(s)
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	(3)		30. Name and address of perein who	completed cause of de	Mall path (Item 23a) (Type, 1801 Pron	Print)	1- 01	M		
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	a J mil	15,0/1	d Lin		
	Registr		AUG 2 8 2006	Ben &	South					

			For State Registrar			Depa	artment of He	ealth and l	Mental Hyg		2006	291	24
	Physici /Medio Examin	al	Decedent's Name (First, Middle Dudy 4a. Facility Name (If not institution,	tine k	Kirbu	1-	Gock 4b. City, Town, or)	2. Date of Dea Month August	Day	Year 2006 county of Death	3. Time of 9:17	Death A M
	Funeral Director	ei	402 Girard S 5. Social Security Number 220-50-7703	treet Apt t-	-2 e (In yrs. last 58	<i>birthday)</i> Yrs.		rsburg If Under 24 Hrs. Hours Min.	(Month, Day	, Year)	ontgomen 9. Birthr Cour 48 Washi	place (State or	Foreign D.C.
	Maryland e-f show	ctor	Usual Residence of Decedent	gomery	10c. City, To		cation					0d. Inside Cit	
	th with the 23e or 28	Funeral Director	10e. Street and Number 402 Girard Str	eet Apt t-2			10f. Zip Code 2087	7		-	en of What Coul		
980	within 72 hours after death with the Maryland ane. then "naturel", or items 23e or 28e-f show the Medical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 X Marri 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? ed 1 Tyes 2 Mil If Yes, Give Year or Dates:			Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2🌠 No	spanic Origin? (S , Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)		Race - Americ Black, White, Specify: Wh		
21215-0036	70 E L	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	s Education t grade completed) College (1-4or 5		(Give life.	dent's Usual Occupa kind of work done di DO NOT use retired) ce Manage	uring most of wo	rking		of Business/In		
Maryland 2	d ta D e	To Be C	17. Father's Name (First, Middle, I Jack Hervey	ast)					ne <i>(First, Middl</i> e, ret Brai:		umame)		
	s 1 and 2 should if Health and Mer item 27 Is marke other treumatic		19a. Informant's Name/Relationsh David W. Gooch		nd	402	ng Address (Street a		t t-2, G	aithe	rsburg,	MD 20	877
Baltimore,	permit. Pages 1 Department of H Importent: If iter eny injury or oth		20a. Method of Disposition 1 ☐ Burial 2 ② Cremation 4 ☐ Donation 5 ☐ Other (Se	ecify)	Metro	poli Cren	osition (Name of matory or other place Ltan natory	200	ust 25	Alex	ation - City or To	Virgi	nia
Bal	permit Depar Impor eny in		21. Signature of Funeral Service I	UVER		I	2. Name and Address East Deer	Park Dr		thers	sburg, M	D 2087	
760,	cate be executed // Medical // Medical end // whysician and ithe burial-transit	Ilcal Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to or as	a consequence	dia ce of): Art ce of):	1 in f	sease	ion			Interval Betwonset and D	
.O. Box 68	death certific e attending p d for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal dea		Ectopic pregnancy Other (specify)			23	d. Date of delive		'ear
Δ.	The law requires that the site has been signed by the bage 2 should be detached.	by	Part II. Other significant condition	ns contributing to death b	ut not resultin	g in the u	inderlying cause give	n in Part I.	23e. Did to		e contribute to t	ne cause of de pably 4 ⊟U	
al Records,		Completed	peripher chronic ob	al Vasula	,		se ory dis			sy med? 2 □ No	24b. Were auto prior to co death? 1 \(\sum \text{Yes}\)	psy findings a mpletion of ca 2 No	ivailable luse of
Division of Vital	To the Hospitel or Attending Physicien: Th within 24 hours after death. To the Funerel Director: After this certificate completely filled in by the funeral director, pag	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin investig 3 Suicide 6 Could referred to medical to medica	28a. Date of Inju (Month, Da	y Year) ury - At home	b. Time o	f 28c. Injury Work	r: 4 🗆 Nursing H	ath (Check only or dome 5 Resid 28d. Describe h 28f. Location (S City or Tow	ence 6 ow injury	occurred		per,
J	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	edical Ce	29a. Certifier 1 Certifyin (Check only one)	g Physicien: To the best Examiner: On the basis o and manner st	f examination	dge, deal and/or ir	h occurred at the time evestigation, in my op	e, date and place inion, death occu	a, and due to the curred at the time, c	cause(s) a date and p	ind manner as s place, and due to	tated. the cause(s)	
)	To the compl	Me	29b. Signature and title of certifier	who completed cause of o	leath (Item 23	a) (Tvoe	29c. License	337		Aug	signed (Month,	,) (
			Dr. Richard 31. Date filed (Month, Day, Year)	Stefunacci	DO ar's Signature	32	Print) SO Start	ing Gat	te a li	Dodl	oine n	12 21	795
0	Sta Regist		AUG 2 9	2006	w B	4	all						

			1 For	State of Maryla		nt of Health and	Mental Hygier	ne2006	29125
			Registrar 1. Decedent's Name (First, Middle, Last)		Certifica	te of Death	Reg.	No.	2 Fire of Dooth
	Physici /Medio	al	Charles N	Jarvin 1	Kirby	n	August 2	Day 2006	3. Time of Death
	Examin	er	4a. Facility Name (If not institution, give s MEMORIA)	HOSPITAL(@ CASTON	y, Town, or Location of Deal EASTON or 1 Year If Under 24 Hrs		4c. County of Death Talbe	
1	Funeral Director		5. Social Security Number 6. Sex 112 - 32 - 6490 112 Usual Residence of Decedent	M 2□F 7. Age (In yrs	Yrs. If Und Months			9. Birthpl 1936 Ma	lace (State or Foreign try) ry La Nd
3	show	'n	10a. State 10b. County	10c. C	ity, Town or Location	ale		10	0d. Inside City Limits
23	death with the Maryland me 23a or 28a-f show fituat be notified at	Funeral Director	10e. Street and Number	000	O 101. 2	OCE S	10g.	Citizen of What Coun	
3)		ınerai	11. Marital Status	12. Was Decedent Eyer in U Armed Forces?	J.S. 13. Was Dec	edent of Hispanic Origin? (Specify Cubart, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - America Black, White, e	
5-0036	ours Fat,	þ	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 W No If Yes, Give Year or Dates:		2 No Specify:		Specify: B10	acK
215-(d 2 should be filed within 72 hours th and Mental Hygiene. ?? is marked other then "natural; traumatic event, the Medical Exa	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Seopndary (0·12)	cation e completed) College (1-4or 5+)	16a. Decedent's Us (Give kind of v life. DO NOT	sual Occupation work done during most of wo use retired)	rking 16b	. Kind of Business/Inc	dustry
<u>≥</u> <u>2</u>	filed wi Hygien other th	ပ္ပ	4		aneing	y Chairs	/-	sehab. (enter
/ land	ould be fi Mental H larked of	To Be	17. Father's Name (First, Middle, Last)	Smith		18. Mothers Na	me (First, Middle, Maid	Kich()	
Sary	2 should and Mer is marks aumatic	-	19a. Informant's Name/Relationship (Ty)	pe, Print)	19b. Mailing Addre	ss (Street and Number or R	-1-3	ty or Town, State, Zip	Code)
. ≥ . ×	s 1 and 2 if Health item 27 i		NING //ge // 20a. Method of Disposition	11 Clamy	301110	MIS HILLY.	Date 200	Location - City or To	21060
$^{\prime}$ $^{\prime}$ $^{\prime}$ $^{\prime}$ $^{\prime}$ Baltimore	Pages nent of ant: if i		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, crematory of ar les Thoma	scenetary 9-	2-065t	-Michael	ls Md.
Ball	permit. Departrimports any inju		21. Signature of Funeral Service License	C. Henr	1510 W	and Address of Facility FUNERALL	- Cambria	Jae MD. 3	11613
	Physician		23a. Pag. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the dealer cause on each line.	Do not enter the mo	ode of dying, such as cardia	c or respiratory arrest,	3/	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):	incident			
	bet nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	7	colomi	,		
760,	ate be executed nysicien and he burial-transit	cal Exar	that initiated events resulting in death) Last	Due to (or as a conse	quence of):	7000	>		
687	ficate p physics to the		\ d	l					
Division of Vital Records, P.O. Box	Hospital or Attanding Physician: The law requires that the death certificat 4 hours after death. Funeral Director: After this certificate has been signed by the attending phylely filled in by the funeral director, page 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3 □Ectopic			23d. Date of delive Month	ry Day Year
S.	es that igned b be deta	by Pt	Part II. Other significant conditions con	tributing to death but not re	sulting in the underlying	cause given in Part I.	23e. Did tobacc	co use contribute to th	
ord	w requir been s should	eted	Hypertens10	<u> </u>			1 🗆 Yes		
al Rec	sician: The law certificate has I irector, page 2 s	Compi					24a. Was an autopsy performed	prior to con death?	osy findings available inpletion of cause of
Vits	ician certifi ector	Be	25. Was case referred to medical examiner?	lospital:			ath (Check only one)		
o d	Phys rthis raldii	٦.	1 Yes 2 No	1 Dinpatient 2L	☐ ER/Outpatient 3☐ [28b. Time of	OOA 4 Nursing I	dome 5 Residence		1)
ion	ttending F death. ctor: After y the funer	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	200. 2000/100 1100 11	nary occurred	
Divis	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At the building, etc. (Special Control of the Control of t	nome, farm, street, factorify)	ory, office	28f. Location (Street City or Town, St	t and Number or Rural tate)	l Route Number,
	ne Hospit n 24 hour ne Funera	ledical (29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examir	ician: To the best of my kner: On the basis of examin and manner stated.	owledge, death occurre ation and/or investigation	ed at the time, date and place on, in my opinion, death occ	e, and due to the cause urred at the time, date	n(s) and manner as sta and place, and due to	ated. the cause(s)
	To the within 2 To the comple	ž	29b. Signature and title of certifier		2	9c. License number	29d. I	Date signed (Month, L	Day, Year)
			30. Name and address of person who co	mpleted all se of death (fee	m 23a) (Type Print)	18P59 T	56 8	12810	6
			Haider Son	Car, NO)	Ed	5/01,	MY	
	Sta Registr		31. Date filed (Month Day Year) 9 21	32. Begistrar's Sign	ature	r)			

State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 10:46 AM August 23, 2006 James Irving Lodges /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Center Cheverly Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Mar. 20, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Year) 1936 **Funeral** 1 XM 2 ☐ F Washington, DC 70 Director 577-68-5964 Usual Residence of Decedent 10c. City, Town or Location 10d. fnside City Limits 10a, State 10b. County 28a-f show Prince George's Palmer Park 1 Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1801 Allendale Court 20785 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or Noff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 ②XNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 28 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black ģ 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) e filed within 7 al Hygiene. Private Elementary/Secondary (0-12) College (1-4or 5+) Entrepreneur 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be finand Mental Fis marked of Oscar L. Millard Irene M. Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s f Health an item 27 is 1801 Allendale Court
Landover MD 20785

20b. Place of Disposition (Name of cemetery, crematory or other place) Dorothy Lodges/Wife 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: if ite sny injury or ot once. 1 ☐ Buriaf 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory 8/28/2006 Beltsville, MD 4 □ Donation 5 □ Other (Specity, 21. Signature of Juneral Service Licenspe 22. Name and Address of Facility Henry S. Washington & Sons Co., Inc., 4925 N. H. Burroughs Avenue, N.E. Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** Cardiorespiratory Failure /Medical Due to (or as a consequence of): Examiner Malignant Ascites Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-transit Metastatic Colon Cancer Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9□ Unknown cate has been signed page 2 should be del Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hypertension Completed Diabetes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 fnpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2XXNo 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: 6 Could not be determined 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Landover Road, Cheverly MD 20785 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LIPISHREE 2. Registrar's Signature 31. Date filed (Month, Day, Year) State 8 2006 AUG 2 Registrar

DHMH 17 Rev 1/2001

P.O. Box 68760

		-	For State Registrar	State of M	aryland	•	artment of H		nd Mer		ene g. No. 200	16 2	91	27
			Decedent's Name (First, Middle, La	st)						Date of Death	1	3. Tir	ne of De	eath
	Physici		Lelia Rebecca I	Limparis						Month August	- 1	ear 06 10:	10 E	М
4	/Medic Examin		4a. Facility Name (If not institution, give	re street and number)			4b. City, Town, or	Location of	Death		4c. County of I			
	Xuiiiii	<u>-</u>	8015 Eastern Ave	enue, #110			Silver	Sprin	ng		Mont	gomery		
	Funeral		5. Social Security Number 6. S	Sex 7. Ag	ge (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 2	4 Hrs. 8.	Date of Birth (Month, Day,	Year) 9.	Birthplace (Si	tate or F	oreign
	Director		578-34-5519	1 □ M 2 □xF	81	Yrs.	Worth's Day's	Tiodis		ly 11,		Virgin	ia	
	pu *	-	Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	cation					10d. Insi	de City	Limits
	sho	2	Maryland Montgo	omerv		,	Silver S	orina					Yes 2	
	28a-1	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of Wha	it Country?		
	with o	ā		ronuo #11	0		151. Esp 0000	209	210		,	USA		
	leath	Funerai	8015 Eastern Av	12. Was Decedent		S. 13. V	Vas Decedent of Hi			Yes or No-	14. Race -	American India	an,	
(0	s after deat or items?	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑	?		Vas Decedent of Hi f Yes, specify Cuba		Puerto Rica	an, etc.)		White, etc.		
93	ours after death with the Marylan ral', or items 23a or 28a-f show Examinant be notified at	by	3 ☐ Widowed 4 ₹ Divorced	If Yes, Give Year or Dates:			I□Yes 2√2No	Specify:			Specify: V	Mite		
5-0036	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show selest Examination modified at	Completed	15. Decedent's E (Specify only highest gr	ducation		16a. Deced	lent's Usual Occupa	ation	of working	1	6b. Kind of Busin	ess/industry		
2121	within ene. then "u	npie	Elementary/Secondary (0-12)	College (1-4or	5+)	life. I	OO NOT use retired)	o					
21	ygier ygier ner th	ខ្ញុ	9			Cash	ier	40.54			Retai	.1		
P	be fit d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother			laiden Sumame)			
<u>\</u>	Mer Marken Marken	2	Irvin Arnett	T - 0::1		101 11 11					avenport			
Maryland	12 should be filed within "h and Mental Hygiene. 7 is marked other than "r		19a. Informant's Name/Relationship (Bernard H. Kilim		d		g Address <i>(Str</i> eet a Eastern <i>1</i>						200	910
	1 and Healt em 2 ther		20a. Method of Disposition	12.11, 111011	20b. PI	lace of Dispo	sition (Name of	1	Date		Oc. Location - Cit			
ğ	Pages nent of nnt: If it		1 Burial 2 Cremation 3		Ce	emetery, crer	natory or other plac	e) A	August	_		,		
Baltimore,			4 ☐ Donation 5 ☐ Other (Speci 21. Signature of Funeral Service Lice		rort		n Cemetery	s of Facility	2006		Brentwoo		ylar	ıd
Ba	Departr Importe eny inju		· (inchen	Solcole		50	Name and Address ancis J. O Univers	sity E	Blvd,	W, Sil	ver Spri	ng, MD	209	901
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each I	d the death ine.	n. Do not ent	er the mode of dyin	g, such as c	cardiac or re	spiratory arre	st,	Interva	ximate al Betwe and Dea	
	Physician		Immediate Cause (Final disease or condition	Cardiop	ulmon	ary Ar	rest					Oriset	and Dec	alli
	/Medical Examiner		resulting in death)	Due to (or as										
		_	Sequentially list conditions,	b. Kartage Due to (or as			se							
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D40 10 (01 43	a consequ	301108 017.								
	certificate be executed Iding physician and Ise as the burial-transit	хаг	that initiated events resulting in death) Last	c Due to (or as	a consequ	uence of):								
8760,	sicial s buri	cal	(€:d.										
9	g phy as th	edical												
Вох	eath certific attending p i for use as i	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Ectopic pregnancy				23d. Date o	f delivery		
	0 0 0	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a			Other (specify)				Month	Day	Yea	ar
P.O	that the de ned by the a detached t	h,	9 🗆 Unknown								1			
	w requires that lhe sbeen signed by lh should be detache	by	Part II. Other significant conditions	contributing to death I	out not resu	ulting in the u	nderlying cause give	en in Part I.			acco use contribu		_	
ord	equir sen s	ted							_	1 ∐ Ye	s 221⊡No 3[Probably	4Unk	known
Vital Records,	> 4 10	Completed								24a. Was ar autopsy	prio	re autopsy find r to completion	lings ava	ailable se of
= E	The law	Son								perform 1 ☐ Yes 2		th? Yes 2□ No	0	
Vita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth	0.00		heck only one	·			
of	S 50	ဥ	1 ☑ Yes 2 ☐ No 27. Manner of Death	I □ Inpati		ER/Outpatier 28b. Time of		4 1400			mce 6 Other (Specify)		
u	te fi	tion	1 X Matural 5 ☐ Pending	28a. Date of Inj. (Month, Da	ay Year)	Injury	Worl	γαι k? Yes 2∐N		. Describe no	w injury occurred			
Division	death. ctor: A y the fu	lica	3 Suicide 6 Could not t	De Place of In	iury - At ho	me, farm, str	eet, factory, office			Location (Str	eet and Number (or Rural Route	Numbe	ar.
Ξ	after Dire	Certification:	4 Homicide determined		tc. (Specify		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or Town,	State)			
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 1 Certifying P	hysician: To the best	of my kno	wledge, deat	n occurred at the tin	ne, date and	place, and	due to the ca	use(s) and mann	er as stated.		
	he Ho in 24 he Fu pletel	Medical	(Check only 2 Medical Exa	miner: On the basis of and manner s	of examinat tated.	tion and/or in			h occurred a					
	Son Son	Σ	29b. Signature and title of certified	4		~	29c. License D381				Nd. Date signed (M August 2			
	5		pho rega	- Oh	~»~	11.70								
			30. Name and address of person who Susan Leggett-Joh			123a) (Туре, 525 Ве	Print) :lcrest Ro	oad, H	lyatts	ville,	MD 2078	2		
	Sta Registi		31. Date filed (Month, Day, Year) . AUG 29	32. Pegist	rar's Signal	ture	eili							

			For State Registrar	State of Ma	aryland / Depa	artment of H		nd Mental Hy	giene Reg. No.		291	29
ı	Physici	ian	1. Decedent's Name (First, Middle,					2. Date of De Month	eath Day	Yeer	3. Time of	Death
	/Medic	cal	Dorothy Evelyn 4a. Fecility Name (If not institution,			4b. City, Town, or	r Location of f	August	1	2006 County of Deat	0405	
	Examin	ner	Chesapeake Wood			Cambridg		Deau		orchest		
Ŧ	Funeral			6. Sex 7. Ag	e (In yrs. last birthday)		If Under 24	Hrs. B. Date of Bi Min. (Month, D	rth	9. Birtl	= L hplace (State or untry)	r Forei g n
	Director		213-20-8072	1□M 2 X JF	82 Yrs.	Months Days	Hours	Sept.	11,1	923 Mar		
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation					10d. Inside Cit	y Limits
	Manyli 1 sho	jo	Maryland Dorche	stor	Hurloc						1 ∑ Yes	_
)	r 28e	irec	10e. Street and Number	SCCI	indi roc	10f. Zip Code			10g. Citi	zen of What Co	untry?	
	th with	Funeral Directo	108 Dogwood D	rive		2164	.3		US	SA		
	tems rems	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H	ispanic Origin In, Mexican, F	n? (Specify Yes or No Puerto Rican, etc.)	D-	14. Race - Ame Black, White		
5	s afte	by Fi	1 ☐ Never Married 2 ☐ Marrie 3 🏿 Widowed 4 ☐ Divorced	ed 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates:	No	1 ☐ Yes 2 💢 No	Specify:			Specify: Wh	ite	
3-003p	72 hours after death with the Maryland naturel', or Items 23e or 28e-f show Jical Examinat must be notified at		15. Decedent		16a. Dece	dent's Usual Occup	ation		16b. Kii	nd of Business/		
	hin 72 9. Medi	plet	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5	(Give	kind of work done of DO NOT use retired	during most o t)	of working				
7	e filed within all Hygiene. other than "	Completed	12		Но	memaker)wn Home	2	
Ē	be file d oth event	Be	17. Father's Name (First, Middle, L					s Name (First, Middle		Sumame)		
_	2 should be and Mental Is marked c	ို	John Adelbert S 19a. Informant's Name/Relationsh		10b Maili	ng Address (Ctroot		orie Grac		Tour State 7	in Coda)	
	d2st than than 171sr traur		Marjorie Pool/D				_		300			
<u>a</u> ,	ss 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mentail Hygiene. I tiem 27 is marked other than "naturel", or flems 23e or 28e-1 show it item 27 is marked other than "naturel", or flems 23e or 28e-1 show rether traumatic event, the Medical Examinar must be notified at	13	20a. Method of Disposition	augneer	20b. Place of Dispo			Hurlock,		cation - City or		
Ē	Pages ent of nt: If i		1 XBurial 2 ☐ Cremation 14 ☐ Donation _5 ☐ Other (Sp				1	/26/2006	Hur1	ock, Ma	ryland	
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	/Medical Examiner	1	resulting in death)	Due to (or as	a construence of):	2 12					0 0	_
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j.	t the c by the achec	hysl	9 ☐ Unknown	9□ Unknown								
ις. L	requires that the een signed by th hould be detache	by P	Part II. Other significant condition			. 1	en in Part I.	23e. Did		se contribute to	the cause of de	ath?
coras	equire en siç ould b		Orabetes, a	ementia	, drem	15		_ 10	Yes 2	No 3□Pro	obably 4 🗆 U	nknown
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r m	ding Physicien: The law h. Atter this certificate has b tuneral director, page 2 s	Con						1 ☐ Yes	22 No	death?	2 No	
Vital	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		Oth		f Death (Check only		_		
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VISION	Attendi er death. rector: A by the fu	Certification;	3 Suicide 6 Could n	ned 286. Place of In	ury - At home, farm, st. c. (Specify)	reet, factory, office			Street and	d Number or Ru	ral Route Numb	er,
5	itel or rel Di rel Di			3								
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the to	edical		g Physicien: To the best exeminer: On the basis of and manner st	f examination and/or in							
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. Licens				e signed (Month		
			Mount	in ou		Ho	599	73	81	24/04		
			30. Name and address of person v				Cambri	dae Marri	and	21612		
	Sta	ate	Patricia Johns 31. Date filed (Month, Day, Year)	32 Beattr	ar's Signature		Campli	uge, Mary	Land	21013		
	Registi		AUG 2	9 2006	we to	And I						

			For State Registrar	State	of Marylan	•	artmen		ealth and Moeath		giene	5 29	130
			Decedent's Name (First, Middle	, Last)						2. Date of Dea	ath	3. Time o	of Death
	Physici /Medic Examin	al	Margaret 4a. Facility Name (If not institution,	Anne give street and no	Lee umber)		4b. City,	Town, or l	Location of Death	SEPTEM1	3ER 5 2006	5:20	A M
	CXCIIIII	CI	St. Mary's Hos	pital				Leo	nardtown		St. I	Mary's	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs.		If Under Months	1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da		rthplace (State	or Foreign
	Director		217-44-3854 Usual Residence of Decedent	10.00 2201	63	Yrs.				Aug. 1	l, 1943 Te	exas	
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside C	City Limits
	Mary a-feh	tor	Maryland St	. Mary's			Lexin	gton	Park			1 🗆 Yes	s 2 ∑ No
	th the or 28; e not	Director	10e. Street and Number				10f. Zip				10g. Citizen of What C	country?	
	ath wi	ral	49168 Demko Roa					206			United		
	er de	Funeral	11. Marital Status	Armed F		S. 13.	Was Deced If Yes, spec	dent of His cify Cuban	panic Origin? (Sp , Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Arr Black, Wh		
36	rs aft	by F	1 Never Married 2 Marri 3 Widowed 4 Divorced	ed 1 Yes, G If Yes, G Year or I	2 ∭MNo live Dates:		1 🗌 Yes	2 XN0	Specify:		Specify:	White	
9-0-	2 hou	ted	15. Decedent	's Education		16a. Dece	dent's Usua	al Occupat	tion		16b. Kind of Busines	s/Industry	
215	thin 7 e. an "n	ple	(Specify only highes Elementary/Secondary (0-12)	1	(1-4or 5+)	life.	DO NOT us	rk done du se retired)	iring most of work	ing			
2	ygien ygien rer th	Be Completed	12				Homem				Own I	lome	
pue	be fill Hall Hall Hall Hall off	Be	17. Father's Name (First, Middle, I	Last)							Maiden Sumame)		
<u> </u>	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f ehow aumatic event, the Medical Examinatinatics colling at	To	Raymond Kirsch 19a. Informant's Name/Relationsh	nin (Tyna Print)		19h Mailir	na Address	(Street a		es Ready	er, City or Town, State,	Zin Codel	
Maryland 21215-0036	d 2 s Ith an 27 is i		Virginia L. Sta		ighter		•				Park, Mary		552
Baltimore,	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylan Department of Heatith and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 ehow eny injury or other traumatic event, the Medical Examinar must be notified at once.		20a. Method of Disposition 1 Burial 2 □ Cremation	3 □Removal from	20b. P	lace of Dispo emetery, crei	sition (Nar. matory or o	ne of ther place)	Date	20c. Location - City of	r Town, State	133
턒	artmer artmer ortant injury		4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service L		Cha	rles M	emori Name an	al Go	in. 9-8-2	2006	Leonardtov Funeral H	m, MD	Α
Ba	permit. Departr Import. eny inj.		Kyle S. S	176	M01206	2000					rdtown, M	-	
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition	complications that	caused the death		er the mod	e of dying				Approxima Interval Be Onset and	ate etween
	/Medical Examiner		resulting in death)	Due to	o (or as a consequence of the co	n Car							
	p ==	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(UI &3 & UUI 1394	aerice vij.							
,	te be executed ysiclen and te burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	o (or as a conseq	uence of):							
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9 ×	ertific ding p	/Mec	IF FEMALE:	220 H vos o	utcome of pregna	nov			·				
.EE Records, P.O. Box 68	The law requires that the death certifical ele hes been signed by the attending phy page 2 should be detached for use as th	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	birth 2 ☐ Feta gnant at time of d	Ideath 3	∃Ectopic pr ∃Other (sp				23d. Date of d Month		Year
ds, P	w requires that the de been signed by the s should be detached		Part II. Other significant conditio	ns contributing to	death but not res	ulting in the u	nderlying c	ause giver	n in Part I.		obacco use contribute		death? Junknown
LEE Reco	The law receive here here bee page 2 shou	Completed									prior to death?		available cause of
45		0	25. Was case referred to medical						26. Place of Deat	1 ☐ Yes		s 2 No	
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	tending Physician: leath. tor: After this certific the funeral director,	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date (Mo	e of Injury nth, Day Year)	28b. Time o Injury		8c. Injury Work		28d. Describe I	now injury occurred		
RE sio		cat	2 Accident investig	of he			М		es 2 No	Ook Lanation (
MARGARET Division	pital or Attendous after death ours after death lerel Director:	Certification;	4 Homicide determi	ned 286 Plac	ce of Injury - At ho ding, etc. (Specif	ome, tarm, str	reet, ractory	/, office		City or Tov	Street and Number or I vn, State)	Rurai Houre Nur	nber,
Z, B	To the Hospital or within 24 hours affer To the Funeral Dir completely filled in it	Medical	29a. Certifier 1 Certifying (Check only one)	Examiner: On the	ne best of my kno basis of examina nner stated.	wledge, deati tion and/or in	h occurred vestigation	at the time , in my opi	e, date and place, inion, death occur	and due to the red at the time,	cause(s) and manner a date and place, and du	as stated. le to the cause(s)
المار	To t To t com	Σ	29b. Signature and title of certifier	Oleh				. License			29d. Date signed (Moi		
			1 / May 1:00 1	Mulle				200	60473		09/05/2	- UE G	
			30. Name and address of person v		•			.T A TO TO	OUN NO C	0650			
	Sta	to	DR. MEHRDAD AK 31. Date filed (Month, Day, Year)		MH PO BO Registrar's Signa	X 527	TEOL	NAKDT	OWN MD 2	0650			
	Registr		SEP 0 6 2006	Keen	15	mode							

			For State Registrar	State of I	Maryland		rtment of H		Mental Hyg	iene •g. No 200	6 29131
	Dhariai		1. Decedent's Name (First, Middle, L	.ast)		·			2. Date of Dea Month	th Day Ye	3. Time of Death
	Physici: /Medic	al .	Charles Lew		gana					25,2006	2:00 p M
	Examin	er	4a. Facility Name (If not institution, g Calvert Memoria				4b. City, Town, or Prince			4c. County of C	alvert
	.				Age (In yrs. las	it birthday)	If Under 1 Year	If Under 24 Hr			Birthplace (State or Foreign Country)
	Funeral Director		217-42-0064	1 X M 2□F	62	Yrs.	Months Days	Hours Mir	Oct. 18	9. 1943	Maryland
	pu ,		Usual Residence of Decedent 10a. State 10b. County		100 City 3	Town or Lo	ontion.				10d. Inside City Limits
	shov ed at	'n			2.		ake Beach				1 TyYes 2 □ No
	the N 28e-f	Funeral Director	MD Calver		CITE	esape	10f, Zip Code		1	log. Citizen of What	t Country?
	3a or		7545 Bayside F	Road			207	32		U.S.A	A.
	death	nera	11. Marital Status	12. Was Decede	ent Ever in U.S.	13. \	Vas Decedent of Hi	spanic Origin? (Specify Yes or No- irto Rican, etc.)	14. Race - A	American Indian, Vhite, etc.
98	or ite	y Fu	1 Never Married 2 Married		No		Yes 2⊠ No	Specify:	,	Specify:	
21215-0036	72 hours after death with the Maryland naturel; or items 23a or 28e-f show iteal Examiner must be notified at	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's			16a Decer	lent's Usual Occupa	ation		16b. Kind of Busine	
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	d la b	Be	17. Father's Name (First, Middle, Lat						ame (First, Middle,		Maske
Maryland	should be nd Mental rmarked o	5		agana		10h Mailie	- Address /Stragt	Cour		telle N	10.
Mai	d 2 sho th and th sm treum	P I	19a. Informant's Name/Relationship Steven L. Lagana		17		•		Tobacco,		_
ē,	s 1 and 2 should of Health and Men item 27 is marke other treumetic	1 3	20a. Method of Disposition	-	20b. Plac		sition (Name of natory or other place			20c. Location - City	y or Town, State
E	Page nent o nt: if iry or	1	1 ☐ Burial 2 X Cremation 3 14 ☐ Donation 5 ☐ Other (Specific Control of Cont	□Removal from Sta cify)	atter		an Cremat	1	-29-06	Alexandri	a, VA
Baltimore,	permit. Pages 1 Deportment of H Importent: If ite any njury or ot once.		21 Sweet re of Funeral Service Lic	seesee			. Name and Addres			eral Home	
_	Per Imp any		Duyan	Tello	ch	8	325 Mt. H	armony	Lane, Owi	ngs, MD	20736
			23a. Part1. Enter the disease, or co shock, or heartrailure. List on	mplications that cau ly one cause on eac	ised the death. th line.	Do not ent	er the mode of dying	g, such as cardi	ac or respiratory ari	est,	Approximate Interval Between Onset and Death
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	cuted nd iransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C	oangiop "		namony (ane	n, a		duy
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Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		h 2 ∏ Fetald	leath 3□	Ectopic pregnancy			23d. Date of Month	delivery Day Year
0	that the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnar 9□Unknow	nt at time of dea m	ith 5∟	Other (specify)				
Ф	es that tigned by		Part II. Other significant conditions	s contributing to dea	th but not result	ing in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contribut	te to the cause of death?
rds	quires in sign	ed by	Pelvic absces	5	<u>,</u>				1 □ Y	es 2□No 3[Probably 4 Unknown
Records,	aw requii ts been s 2 should	Completed	Hyper tension						24a. Was a	an 24b. Were	e autopsy findings available to completion of cause of
H.		Com	Thrombocy to run	٠					perfor	med? _ deat	h? Yes 2□ No
Vital	i cien : Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Heavital: 4	,		100		eath (Check only or	ne)	
of \	Physicien: this certificated rail director,	5	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Hhp		R/Outpatier		4 Idulaling		ence 6 Other (Specify)
O	Jing After fune	tlon	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month,	Day Year)	Injury	Work	(? Yes 2 □ No	1	on injury occurred	
Division	Attending r death.	Certification:	3 Suicide 6 Could not 4 Homicide determine		f Injury - At hom	e, farm, sti	eet, factory, office		28f. Location (S City or Tow		or Aural Route Number,
Ö	s afte	Cert	4 Homicide	building	, etc. (Specily)				Ony 0, 701		
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the b maminer: On the bas and manne	is of examination	ledge, deat on and/or in	n occurred at the tim vestigation, in my op	ne, date and pla pinion, death oc	ce, and due to the c curred at the time, c	ause(s) and manne date and place, and	er as stated. due to the cause(s)
	To th within To th	Ň	29b. Signature and title of certifier				29c. License		:	29d. Date signed (M	
•			> U/ , ma				060	770		8/251	
	6		30. Name and address of person with REB JABE	R 100	HUSP ITY	n R	D., PRINI	ce fri	EDENICK,	mp 20	0678
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) AUG	2 8 2006 ▶	gistra s Signatu	J.	Sperte				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 5 2. Date of Death 1 Decedent's Name (First, Middle, Last) Day **Physician** August 27, 2006 10:00 PM Anne Lesniak /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Charles 24 Tadcaster Circle Waldorf If Under 1 Year If Under 24 Hrs. B. Date of Birth (Month, Day, V. June 24, 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** ay, Year) 1 ☐ M 2 🛣 F Yrs 91 Ĩ915 Director 060-05-6092 Usual Residence of Decedent bould be filed within 72 hours after death with the Maryland Mental Hygiene. 10a State 10c. City, Town or Location 10d. Inside City Limits 10h County I Health and Mental Hygiene. Itam 27 Ie marked other than "natural", or Itame 23a or 28a-f ehow other traumatic evant, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland | Charles Waldorf 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 12340 Walker Place 20602 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☑ No Specify: Completed by 3 ☐ Widowed 4 X X ivorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 American Kennel Club Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be . Pages 1 and 2 should be ment of Health and Menta tant: If Itam 27 le marked Michael Lesniak Victoria Pyccko 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12340 Walker Place, Waldorf, MD 20602 <u> Steven Prentice - Nephew</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. * 4 □ Donation 5 □ Other (Specify) Huntt Crematory 8-29-2006 Waldorf, MD 21. Signature of Edheral Service Licensee 22. Name and Address of Facility M01391 3035 01d Washington Rd POB 156, Waldorf, MD 20604 Huntt Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MEARI CONGESTIVE **Physician** disease or condition resulting in death) /Medical Examiner ROIOMYO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by My POTHYROIDISM 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 Yes 2LXNo 1 Tyes or Attanding Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 ther (S ecil) \$15755 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 XNo 10 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred UUING Certification: After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation s after death. 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide within 24 hours a Filled fying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 **X** Ce 2 ☐ Me Medical completely (Check only one) **Xaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 3885 2006 Name and address of person who completed cause of death (Item 23a) (Type, Print) # 307 CUNTON 7501 SURRATIS . KAM ando KOBO ٠ ٧ AUG 2 31. Date filed (Month gistrar's Signature State 9 Registrar

		•	- State Registrar	State of Maryland /		ent of Health a ate of Death		Reg. No.	2006	29133
ı	Physici		1. Decedent's Name (First, Middle, Last)	PPO			2. Dat	e of Death nth Day	Year	3. Time of Death
	/Medic Examin		4a. Fecility Name (If not institution, give st	reet and number)		ty, Town, or Location of			2006 County of Death	10 30 A
	LXamin	-1	COASTAL HOSPIC	e At The Lake	e S	alisbury	MD	U	licomie	.0
	Funeral Director		5. Social Security Number 6. Sex 120 03 - 2295 120 Usual Residence of Decedent	7. Age (In yrs. last	yrs. If Und Month	der 1 Year If Under is Days Hours	24 Hrs. 8. Dat Min. (Mo	e of Birth onth, Day, Year)	9. Birthp Coun	lace (State or Foreign ntry)
	yland yland	1	10a. State 10b. County	10c. City, To	own or Location				1	0d. Inside City Limits
	e Mar	cto	PA YORK	SP	RING	FROVE				1 PYes 2 No
	vith th	Funeral Director	10e. Street and Number			Zip Code	272		zen of What Coun	ntry?
	ns 234	eral	2115 YINGLIN	2. Was Decedent Ever in U.S.		7362-8	1 1		SA 14. Race - Americ	an Indian,
21215-0036	s 1 and 2 should be filed within 72 hours after deeth with the Maryland if health and Mental Hygiene. Item 27 ie marked other then "natural", or items 23a or 28a-f ehow other treumstice event, the Musical Examinar must be motified at	5	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		cedent of Hispanic Ori pecify Cuban, Mexican 2 No Specify:	, Puèrto Rican,		Black, White,	
2-0	72 ho	Completed	15. Decedent's Educ (Specify only highest grade		6a. Decedent's U (Give kind of	work done during most	t of working	16b. Kir	nd of Business/Inc	
121	within then then	du	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DONOT		-	TOC	EIG & JO	
	Hygie other	Be Co	17. Father's Name (First, Middle, Last)				er's Name (First,	Middle, Maiden		
/lan	should be ind Mental marked o	To B	MAURICE DAVIE	LEPPO		EM	mA A.	ACKER	MAN	
Maryland	2 sho		19a, Informant's Name/Relationship (Typ			ess (Street and Numbe			4.	Code)
	Health Health tem 27 other tr		20a, Method of Disposition		of Disposition (A	ESIDE DR	SAUSIS	The second secon	cation - City or To	own. State
nor	ages ant of it; if it y or o		1 Surial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State . ceme	otery, crematory of	r other place)	3 \30\ce		nover, P	
Baltimore,	permit. Pages 'Department of Important; if Ite eny injury or of once.	1	21 Signature of Funeral Service License	6	22. Nama	and Address of Facilit	La I Home	F CO Ber	61	
ä	Depa Impo eny ir	(1)	C Intenstored	3 mosule	BI	and Address of Facility Syck Func	D 2181	4		
	Physician /Medical Examiner	amlner	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to for as a consequence	ce of):	n Tu	mor			Interval Between Onset and Death
,8200	cate be executed physicien end the burial-transit	dical Examiner	resulting in death) Last	Due to (or as a consequent	ce of):					
.O. Box 6	death certifi e attending id for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ic. If yes, outcome of pregnancy 1 Live birth 2 Fetal dec 4 Pregnant at time of death 9 Unknown	ath 3 ☐Ectopic			2	23d. Date of delive Month	ery Day Year
rds, P	The law requires that the ine has been signed by the bage 2 should be detache		Part II. Other significant conditions conf	nbuting to death but not resulting	g in the underlyin	g cause given in Part I.	. 23		-	ne cause of death?
Vital Records,	⊕ <u>~</u>	Completed					10	a. Was an autopsy performed? Yes 22 No	prior to cor death?	psy findings available impletion of cause of 2 2 100
Ž		To Be	25. Was case referred to medical examiner? 1 Yes No	ospital: Impatient 2 EP/	Outnatient 3		of Death (Chec		☐Other (Specify	w)
ion of	After After		27. Manner of Death SNatural 5 Pending 2 Accident investigation		b. Time of Injury	28c. Injury at Work?	28d. De	escribe how injury		1
Division	at or Atters s efter des	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, street, fac	tory, office		cation (Street and y or Town, State,	d Number or Rura)	il Route Number,
	To the Hospital or Attend within 24 hours efter death To the Funeral Director: crimpletely filled in by the	edical	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	ician: To the best of my knowled er: On the basis of examination and manner stated.	dge, death occurr and/or investigat	ed at the time, date an ion, in my opinion, dea	d place, and due th occurred at th	e to the cause(s) te time, date and	and manner as st place, and due to	tated. o the cause(s)
	Noth Tott	ž	29h Signature and title of certifier	1 000		29c. License number	75		e signed (Month,	
	1500		JOH CO	NVW	a) (Tage 8 : 1)	D060	1/8		1-78-	0(
8	200		20. Name and address of person who con			PO BOX 17	23 Sa	elist W.	7-28- 20 218	62
7	Sta Regist		31. Date filed (Month, Day, Year)	32. Hegistrar's Signature	Short),		

DHMH 17 Rev 1/2001

ORIGINAL.

State of Maryland / Department of Health and Mental Hygiene 006 Certificate of Death Reg. No. 2. Date of Death 3. Time of Deatha 1. Decedent's Name (First, Middle, Last) Day Month **Physician** M August 25,2006 4:39 Lankford Virginia /Medical 4c. County of Deeth 4h City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Parsonsburg Wicomico 32852 Powell Street If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2X F Yrs. 223-18-6025 5/4/1915 Virginia Director Usual Residence of Decedent permil. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Exp. illustrative rottlined at 90cg. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 □ No Completed by Funeral Director Wicomico Parsonsburg Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 32852 Powell Street 21849 14. Rece - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: white 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Shirt Factory Seamstress 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Bessie L. Colona John t. Killmon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 32828 Powell St., Parsonsburg, MD 21849 Billye Raye Eder/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Springhill Memory 1 Burial 2 Cremation 3 Removal from State 8/28/06 Hebron, MD * 4 ☐ Donation 5 ☐ Other (Specify) Gardens Thornowly Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 21. Sinn ture of Funeral Shrvice Licensee Approximate Interval Between Onset and Death Part 1. Enter the disease, of complications that caused the shock or heart failure. List only one cause on each line. Do not enter the mody of dying, such as carriac or respiratory arrest, death. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as wo insequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine rsician and e burial-transit Due to (or as a consequence of) P.O. Box 68760 Physiclan/Medical as the b IF FEMALE: detached for use 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Wes decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica 25. Was case referred to medical 26. Place of Death Check only one Be examiner? Other: 4 Nursing Home 5 esidence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1-Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 30. Name and address of peleon who completed AMM () (Walking MM) ath (Item 23a) (Type, Psynt) 32 Higistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/200

ORIGINAL

DORIS

		-	_ State	State of Maryland / Dep	partment of Health and Nertificate of Death	lental Hygien		29136
			Registrar 1. Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	Physicia	8	GRACE AN	N MITRPHY		Month Da		1.20 am
- 4	/Medic Examin		4a. Fecility Name (If not institution, give str		4b. City, Town, or Location of Death	August 25	c. County of Death	1:30 am
			9895 Good Luck Roa	d, #4	Lanham		Pr. Georg	es
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda)	Months Days Hours Min.	8. Date of Birth (Month, Day, Year		place (State or Foreign ntry)
蒙	Director		577-44-4480 Usual Residence of Decedent	72 Yrs.		February 1,	1934 Washi	ngton, DC
	land ow	1	10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits
	Mary Indu	ţ	Maryland Pr. Georg	es Lanham				1 ☐ Yes 2 ☐XNo
	r 28e	lrec	10e. Street and Number	<u>CO</u>	10f. Zip Code	10g. C	itizen of What Cou	ntry?
	death with the Maryland ims 23a or 28e-f show right be notified at	Funeral Director	9895 Good Luck Road		20706		.S.A.	
	r dea	neu	11. Markar Olalas	Armed Forces?	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
36	s afte	by Fi	1 Never Married 2 Marned 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ x No If Yes, Give Year or Dates:	1 ☐ Yes 2 🙀 No Specify:		Specify:	
21215-0036	hour	edt	15. Decedent's Educa	ation 16a Dec	edent's Usual Occupation		Whi Kind of Business/Ir	-D-
5	n n	plet	(Specify only highest grade Elementary/Secondary (0-12)	Completed) (Git life College (1-4or 5+)	re kind of work done during most of work . DO NOT use retired)	ang		
27	d with giene ar the	Completed	12		etary		. S. Gov'	t
멀	al Hy al Hy d oth	Be (17. Father's Name (First, Middle, Last)		18. Mother's Nam	e (First, Middle, Maide	ın Sumame)	
yla	ould to Ment arked atic o		Allen G. Greer			E. Harris		0-4-1
Maryland	2 short and raum	1	19a. Informant's Name/Relationship (Type		lling Address (Street and Number or Rui	,		p Code)
e, l	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel; or items 23a or 28e-f show way injury or other traumatic event, the Michigal Examination at apps.	1	Brenda L. Murphy (20a. Method of Disposition	20b. Place of Dis			NC 25515 Location - City or T	own, State
20	nt of little it or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	ematory or other place)	20/06	-11- Ch	-1- T7 A
altimore,	orthe principal injury		4 □ Donation 5 □ Other (Specify) 21. ignature of Fun → Service Licensee		1 Memorial Park 8/3 22. Name and Address of Facility Mus			
Ba	Depermine Depermine Important in sun icum icum icum icum icum icum icum icum		James 1.		1102 W.Broad St. Fa	rpny raiis alls Church	onuren F	uneral home
¥.	- 4		23a. Part1. Enter the disease, or complic shock, or heart lailure. List only one	ations that caused the death. Do not e			,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition					Onset and Death 6 Months
1	/Medical		resulting in death)	Due to (or as a consequence ol):	cer			o nonens
	Examiner		Sequentially list conditions, b.					
	sit s	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				
	and and I-tran	Examine	that initiated events c. resulting in death) Last	Due to (or as a consequence ol):				
8760,	death certificate be executed e attending physician and od for use as the burial-transit							
687	ficate t p physical as the b	Physician/Medical	U.					
Box	leath certifica attending ph I for use as th	I/M	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 □Ectopic pregnancy		23d. Date of deliv	•
	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐No		5 ☐ Other (specify)		Month	Day Year
P.0	The law requires that the de ate has been signed by the bage 2 should be detached	Phys	9 Unknown		in Death	23o Did tobacco	o use contribute to	the cause of death?
	res tha igned be det	ρ	Part II. Other significant conditions cont	nbuting to death but not resulting in the	underlying cause given in Part I.	1 ☐ Yes		bably 4 Unknown
Records,	v requir been si should	Completed					25	
3ec	The law cate has t page 2 s	d E				24a. Was an autopsy performed?	prior to c death?	topsy lindings available ompletion of cause of
<u>m</u>					00.00	1 ☐ Yes 2 🛣 N	Vo 1 ☐ Yes	2 No
Vital	sicia Ser	o Be	25. Was case relerred to medical examiner? 1 ☐ Yes 2 📆 No	ospital: 1 Inpatient 2 ER/Outpa	Other	th (Check only one) ome 51 Residence	6 □Other (Spec	entv)
of		 	27. Manner ol Death	28a. Date of Injury (Month, Day Year) 28b. Time (njury	of 28c. Injury at	28d. Describe how in		
ion	불목호	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Monal, Day real)	M 1 Yes 2 No			
Division		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, larm, building, etc. (Specify)	street, lactory, office	28l. Location (Street City or Town, Sta		ral Route Number,
	urs after or rai Dir							
	To the Hospitei of within 24 hours a To the Funeral Completely filled it	edical	29a. Certifier 1 Certifying Phys (Check only 2 Medical Exemin	er: On the best of my knowledge, do er: On the basis of examination and/o and manner stated.	eath occurred at the time, date and place r investigation, in my opinion, death occu	, and due to the cause rred at the time, date a	(s) and manner as and place, and due	to the cause(s)
	To the To the comple	Med	29b. Signature and title ol certifier	and married stated.	29c. License number	29d. [Date signed (Month	n, Day, Year)
	· ·		> Clouds (M	D 25079	8	3/25/06	
	60		30. Name and address of person who con	npleted cause of teath (Item 23a) (Ty			/ - V	
2	X		Don Yablonowitz.	MD 7404 Executi	ve Place, Lanham, N	1D 20706		
1.8		ate	31. Date filed (Month, Day, Year) AUG 2 9 2	32. Registrar's Signature				
40	Regist	Tar	מע מי שוריים	COLLEGE.	(Deva)			

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygienes Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death August 27, 2006 **Physician** Edmond William John G. Murphy РМ 9:03 /Medical 4c. County of Death 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Annapolis Anne Arundel Anne Arundel Medical Center 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) 5. Social Security Number **Funeral** Days 11☑M 2□F 57 Yrs. Aug. 25, 213-54-8860 1949 Ireland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits f show other treumatic event, the Madical Examiner must be notified at XXYes 2 ☐ No Director Maryland Anne Arundel Crofton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 1650 Albermarle Dr. 21114 or Items 23a death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 21 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Widowed 4 Divorced 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other treumatic event, the M. Elementary/Secondary (0-12) College (1-4or 5+) Local 99 Stationary Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Seamus Murphy Eileen O'Shea 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Barbara F. Murphy / Spouse 1650 Albermarle Dr. Crofton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Metropolitan Crematory 8-29-06 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility BEALL Funeral Home 21. Signature of Funeral Service Licensee 6512 NW Crain Hwy Bowie, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner as the burial-transit death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 | Fetal death ło Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown been signed by should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ entricular Vocelycovalia 3 ☐ Probably 4 ☐Unknown 1 ☐ Yes 2 ☐ No Completed Arcelinoid Hemorrh og @4a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed has Thrombocy 1 ☐ Yes 2 ☐ No topenia 1 ☐ Yes 3/2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 1 Yes 2 No 2 5 ☐ Residence 6 ☐ Other (Specify) funeral dir 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: al or Attending P s after death. Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Hospital ithin 24 hours of Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifler er on o com eted cause of death (Item 23a) (Type, Print) Name and address of Medical Date filed (Month, Day, Year) 32. Registrar's Si AUG 2 9 2006 Registrar

			1 - State Registrar	State of N	Marylan	d / Depa <i>Cer</i>	artment of H tificate of L	ealth and Death	Mental Hyg	giene Reg. No. 200	6 29138
I	Physici /Medic		Decedent's Name (First, Middle Beverly			Mathis			2. Date of Dea Month August	ath Day Ye	3. Time of Death
7	Examin		4a. Facility Name (If not institution Doctors Communi				4b. City, Town, or Lanhan		th	4c. County of D	
	Funeral Director		5. Social Security Number 133-34-1546	6. Sex 7. / 1 ☐ M 2 ☑ F	Age (In yrs. 59	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Birt (Month, Day Februar	y, _{Year)} 1947 9. y 17 N	Birthplace (State or Foreign Country) EW YORK
	aryland show	-	Usual Residence of Decedent 10a. State 10b. County			y, Town or Lo	cation				10d. Inside City Limits
	with the M s or 28a-f	Directo	10e. Street and Number	ce George's	<u> </u>	Lanham	10f. Zip Code			10g. Citizen of What	1 🖾 Yes 2 🗍 No t Country?
336	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than *natural', or Items 23e or 28e-f show important: if Item 27 is marked other than *natural', or Items 23e or 28e-f show any Injury or other traumatic avant, the Modifiel Excluding roual be notified at DDGs.	by Funeral Director	9316 Bandera S 11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	12. Was Deceder Armed Force	s? XNo	t	20706 Was Decedent of Hi f Yes, specify Cubai 1 □ Yes 22 No	spanic Origin? (n, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)		American Indian, Vhite, etc. Black
21215-0036	d within 72 hou giene. or then *nature the theu call E	Completed by	15. Decedent (Specify only highes Elementary/Secondary (0-12) 12th	t's Education st grade completed) College (1-4c	or 5+)	(Give life. L	dent's Usual Occupa kind of work done o DO NOT use retired	turina most of we	orking	16b. Kind of Busine	
Maryland	uld be filed fental Hyg rked othe tic svsnt,	To Be C	17. Father's Name (First, Middle, Luther Johns	•					_{ame (First, Middle,} Jean Ken	Maiden Sumame)	
	alth and N		19a. Informant's Name/Relationsl Roger Peter Mat		d		g Address <i>(Street a</i> Bandera S			or, City or Town, Stat aryland	re, <i>Zip Code)</i> 20706
Baltimore,	Pages 1 e		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		te C	emetery, cren	sition (Name of natory or other place	010	Date 28/2006	20c. Location - City	or Town, State
Balti	permit. Departn Importe sny Inju		21. Signature of Funeral Service	Licensee La La L	10		Name and Addres			cins Funer er,Marylan	al Home
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	pnly one cause on each	ı line.		er the mode of dying Hyperter				Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Sequentially list conditions.	b	as a conseq						
68760,	icate be executed physicien and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	as a consequal						
P.O. Box 68	death certif e ettending id for use as	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcor 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Feta	I death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
	requires that the dei een signed by the e nould be detached f		Part II. Other significant condition	жs contributing to death	n but not res	ulting in the ur	nderlying cause give	en in Part I.			e to the cause of death? Probably 4苍Unknown
I Records,	The law ete has b page 2 st	Completed					···		24a. Was autop perfo 1 - Yes	rmed? prior	a autopsy findings available to completion of cause of h? Yes 2 🖾 No
of Vital	cian	Be	25. Was case referred to medical examiner?	Hospital:		•	Othe		eath (Check only o		
ion of	fe fe	atlon: To	1 译 Yes 2 □ No 27. Manner of Death 1 孫Natural 5 □ Pendin 2 □ Accident investig	28a. Date of li		ER/Outpatien 28b. Time of Injury	28c. Injury Work	4 Nursing at ? ∕es 2 No	Home 5 Resid	dence 6 Other (S	Specify)
Division	To the Hospital or Attendi within 24 hours efter death. To the Funaral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could i 4 ☐ Homicide determ	ined 286. Place of	Injury - At ho etc. (Specif	ome, farm, str	eet, factory, office		28f. Location (S City or Tox	Street and Number o vn, State)	r Aural Route Number,
	the Hospi in 24 hour the Funar ipletely fill	edical	(Check only 2 Medical one)	ng Physician: To the be Examiner: On the basis and manner	s of examina	wledge, death	n occurred at the tim vestigation, in my op	e, date and place pinion, death occ	ce, and due to the curred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	With	Σ	29b. Signature and title of certified	en /	27	200	29c. License	number 55%	_	29d. Date signed (M August 2	
R	(15)		30. Name and address of person Salador Sylve	ester M.D.			Print)			nd 20785	
6	Sta Registi		31. Date filed (Month, Day, Year) AUG 2 9 20	22. Regi	strar's Signa	ature	the state of the s				

		•	For State Registrar		State o	of Maryla		artment of I <i>rtificate of</i>					2006	29	9139
	Dhuolai		1. Decedent's Name	(First, Middle, La	st)						2. Date of Dea	ath Day	y Year	3. Time	of Death
	Physici /Medic		MATTIE			1TCHEL	LL				UGUST	22,	2006	7:43	BP M
J	Examin	er	4a. Facility Name (II 9262 EDMC	-		imber)		4b. City, Town, of GREENBE		of Death			County of Deal		
	Funanal		5. Social Security N	umber 6.5	Sex	7. Age (In y	rs. last birthday			r 24 Hrs.	8. Date of Birt	h		hplace (State	e or Foreign
	Funeral Director		326-16-23		I	87	Yrs.	Months Days	Hours	Min.	JUNE 6	y, Year) • 19	19 GEO	RGIA	
	pura *	}	Usual Residence of 10a, State	Decedent 10b. County		10c.	City, Town or L	ocation						10d. Inside	City Limits
	Maryla -f eho	rot	MD	PRINCE G	EORGES		REENBELT								es 2 No
	h the	Director	10e. Street and Nur	nber				10f. Zip Code				10g. Citi	izen of What Co	ountry?	
	23a c	ralD	9262 EDMC	NSTON RD				20770					U.S.A.		
Maryland 21215-0036	J within 72 hours after death with the Maryland jone. rithan "natural", or Itema 23a or 28e-f ehow the Madical Examinat must be notified at	by Funeral	11. Marital Status 1 ☐ Never Marri 3 【 Widowed	ed 2 Married	Amed F	2X No ive		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 21☐ No			cify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit Specify: B		
5-0	72 ho	eted	(Spec	15. Decedent's E)	16a. Dece	dent's Usual Occu	pation during mo	st of workin	a	16b. Ki	ind of Business	Industry	
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92	be filed water Hygie of other terms	ပို	17. Father's Name	(First, Middle, Last,)		GOESI	. DERVICE			(First, Middle,				· · · · · · · · · · · · · · · · · · ·
lan	Mental Mental arked o	ToB	WILLI'S D	UKES					BEI	RTHA	PATR	ICK			
ary	2 should and he is main aumain		19a. Informant's Na	ame/Relationship (Type, Print)		19b. Mail	ing Address (Street	and Num	ber or Rural	Route Numbe	r, City o	or Town, State,	Zip Code)	
				AL/GRAND	DAUGHTE			EDMONSTO	N DR						
nore	A 0			oosition □ Cremation 3 □ 5 □ Other (Specil		State	cemetery, cre	osition (Name of matory or other pla ULCHRE CE		9/2/2	ate 2006		ocation - City or SIP , ILL		
Baltimore,	permit. Page Department of Important: If eny injury or		21. Signature of Fu		•	00	7 2	2. Name and Addre	ess of Fac	ility J	. в. ј		ARYLANI		
	au z v u		23a. Part1. Enter the	he disease, or com	eplications that	caused the de							MICE ESTATE	Approxin	
	Physician		shock, or hea Immediate Cause (rt failure. List orfly (Final	one cause on	each line.	ART FAII		3,		, , , , , ,			Interval E Onset ar	
	/Medical		disease or conditio resulting in death)	n (a Due to	(or as a cons									
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O. Box	0 0	Physician/M	23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months? ☐ No		birth 2 ☐ F nant at time o	etal death 3	□Ectopic pregnand □ Other (specify) _	у				23d. Date of de Month	Day	Year
Δ.	2 2 8	ρ	Part II. Dther signif	icant conditions	contributing to	death but not	resulting in the t	underlying cause gr	ven in Par	11.	1		use contribute to		
Records,	law requir as been s 2 should	Completed									24a. Was	an	24b. Were as		
Ä	The ete h page	E OC									perto	rmed? 20 No	death?	7.7	a cause of
Vital	Physician: this certific rai director,	Be	25. Was case refer examiner?		Hospitali			100		ce of Death	(Check only o	ne)			
of	Physic this crain direction	7.	1 XYes 2 ☐ 27. Manner of Deat		Hospital: 1 28a. Date		ER/Outpatie	EIL 3L DOA			te 5 ∑ Resid 8d. Describe I		6 □Other (Spe	city)	
		tlon	1 Accident	5 Pending Investigatio	(Moi	nth, Day Year		Wo	ork?]Yes 2[00. 20001100 1	iow injui	ny document		
Division	i or Attending after death. Director: Afte I in by the fune	Certification:	3 Suicide 4 Homicide	6 Could not be determined	e 28e. Plac	e of Injury · A ding, etc. (Spe	t home, farm, si	treet, factory, office		2	8f. Location (S City or Tox		nd Number or R	ural Route N	umber,
	tospita t hours unerei	Medical C	29a. Certifier (Check only one)	1 Certifying Pl 2 Medical Exa	minar: On the	e best of my l basis of exam	knowledge, dea ination and/or i	th occurred at the to	ime, date a	and place, a eath occurre	nd due to the	cause(s)) and manner as d place, and due	s stated. to the caus	e(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and	title of certifier				29c. Licen	se numbe	,		29d. Da	te signed (Mont	h, Day, Year	-)
			1 Ais	Bu 158	حبس			D48	3158			AUGI	JST 23,	2006	
R	- (4)		30. Name and addr	ess of person who	completed cau	xon HI	Item 23a) (Type LL RD S	Print) UITE 500	OXON	HILL					
	Sta Registi		31. Date filed (Mon				gnature								-

State of Maryland / Department of Health and Mental Hygiene Reg. No 2006 1 - For State Registrar Certificate of Death 3. Time of Death 2 Date of Death Decedent's Name (First, Middle, Last) Day Year Physician 7:30A M 21<u>,</u> AUGUST 2006 DELORES MARY MARTIN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGES LAUREI. LAUREL REGIONAL HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Months Days 1 □ M XXF Yrs SEP. 09, 1937 MARYLAND 68 Director 218 34 6572 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other treumatic event, the Medical Examinar must be notified at once. XXYes 2 No Director MD PRINCE GEORGES LAUREL 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20708 UNITED STATES 10307 BALSAMWOOD COURT Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes X2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes ※XXNo Specify Specify: BLACK δ 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) WAREHOUSE EMPLOYEE PRIVATE 12TH 18 Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be THOMAS ANDREW WOODLAND BERTHA BARNES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) UPPER MARLBORO, MD20772 8815 WOODSTOCK DRIVE WEST ELRODY D. MARTIN / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State FORT LINCOLN CEMETERY 08/26/2006 BRENTWOOD, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician PULMONARY EMBOLISM /Medical Due to (or as a consequence of) Examiner LUNG CANCER S uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Š PLEURAL EFFUSION , DIABETES MELLITUS, CORONARY 1 Yes 2 No 3 Probably WUnknown Completed 24b. Were aulopsy findings available prior to completion of cause of death? 24a. Was an ARTERY DISEASE autopsy performed 1 Yes 2 No 1 ☐ Yes XXNo director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes XXNo XX Inpatient 2 ER/Outpatient 3 DOA After this funeral of Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification; Watural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident efter death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ŏ To the Hospital of within 24 hours of To the Funeral D 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10050412 26 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10724 LITTLE PATUXENT PKWY. #200 COLUMBIA, MD 21044 NATESA P. SHANMUGAM, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 2 9 2006 Registrar

			Please	• •	K Indelible Ink. Ensure A		
			1 _ For	State of Maryland / I	Department of Health and I		
			Registrar		Certificate of Death		No. 2006 29141
	Physici	an	Decedent's Name (First, Middle, La	st)	11:1		Day Yeer 3. Time of Death
	/Medic		Charles	Aaron	1V11/e5	August	11,2006 8:05 PM
)	Examin	er	4a. Facility Name (If not institution, giv		4b. City, Town, or Location of Death		4c. County of Death
			Chesapeake Fu				Anne Arundel
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. last bi	Months Davs Hours Min.	(Month, Day, Yea	9. Birthplace (State or Foreign Country)
	Director		214-60-9775	32	Yrs.	Oct. 24,1	953 North Carolina
3	2 ≱_		Usuel Residence of Decedent 10a. State 10b. County	10c. City, Tow	n or Location		10d. Inside City Limits
	a-f ahow	ក	MD /	1	1 - 1		1 1 Yes 2 □ No
S	288-1	ect	10e. Street and Number	Anne's C	nester 101. Zip Code	100	Citizen of What Country?
R:	0 0	급	100. Strong and Number	14(01/	2//19	109.	11 6 0
12	rz nouis aner obain win nie maryen nstural', or itama 23a or 28a-f ahow urei Exemirer maat be notified at	Funeral Director	21- Sher	12. Was Decedent Ever in V.S.	13 Was Decedent of Hispanic Origin? (S	pecify Ves or No-	14. Race - American Indian,
0	it it	Ë	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	Black, White, etc.
5-0036		by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 202/No Specify:		Specify: Black
ŏ	natural',	P	15. Decedent's E	ducation 16a	. Decedent's Usual Occupation	16b	Kind of Business/Industry
215		Completed	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(Give kind of work done during most of wor life. DO NOT use retired)	rking	
212	r than "	E	12	Conege (1-401 5+)	Carpenter	C	onstruction
	other other	Bec	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maid	len Sumame)
lar	marked other	To B	Houseo	Miles s	R. Dara	thy An	n Wright
Maryland	and Men ie marke		19a. Informant's Name/Relationship (o. Mailing Address (Street and Number or Ru	ral Route Number, Cit	y or Town, State, Zip Code)
111			Haron 1	Miles 2	1. Cherman Way	-Chester	r. Maryland 21619
ω,	permit. Pages 1 end Department of Health Important: If Itam 27 any injury or other tr onca.		20a. Method of Disposition	l nomet	of Disposition (Name of ary, crematory or other place)	Date 20c.	. ocation - City or Town, State
6	permit. Pages Department of I Important: If Its any injury or o		1 PBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special	Memoval from State		9/06 Gx	asonville, MD
	orter	1		nsee A			asonv. He, MID.
B	Departr Departr imports any inj		Danollo.	or allowed	HENRY FUNERAL	HOME, PA	ha' 1 - MD 21613
			23a. Par() Enter the disease, or com	plications that caused the death. Do	22. Name and Address of Micility HENRY FUNERAL 510 Washi wortan not enter the mode of dying, such accardiac	or respiratory arrest,	Approximate
			shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	1 1		Interval Between Onset and Death
	hysician /Medical		disease or condition resulting in death)	a. Cod STOGE Due to (or as a consequence	renal disea	25C	weeks
	Examiner			Dub to (or as a consequence	. 617.		
		ē	Seventially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence	or):		
3	insit	듵	cause. Enter Underlying Cause (Disease or injury				
_	be executed icien and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequence	of):		
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89	ettending physion locates of the total of th	Completed by Physician/Medic		_ u			
Вох	nding use e	N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of delivery
ŭ	ette 1 for	cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	n 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
P.O.	y the	lys	9 Unknown	9□ Unknown			
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ទូ	been s	lete				24a. Was an	24b. Were autopsy findings available
Re	scentificete has birector, page 2 s	Ę				autopsy performed	prior to completion of cause of death?
a	ficete pr. pa	e C	25. Was case referred to medical		00 8118	1 Yes 2	No 1 Yes 2 No
5	certi	00	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/O	Othor	ath (Check only one)	C []()()
of Vital Records,	rny rthis raid	7:	27. Manne of Death	28a. Date of Injury 28b.	utpatient 3 DOA Color 4 Vursing F Time of Injury 28c. Injury at Work?	28d. Describe how in	6 ☐Other (Specify)
on !	fune fune	ţ	1 Actural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury Work? M 1 Yes 2 No		
isi	deal ctor y the	flca	3 Suicide 6 Could not b	B CO. Black Allelian Athense	arm, street, factory, office	28f. Location (Street	and Number or Rural Route Number,
Division	offer Dire	Certification:	4 Homicide	building, etc. (Specify)	,	City or Town, St	tate)
	Hoopital of Attending Physician: The law requires that the beath certificate by hours placed as the standing physicians bless bless bless signed by the attending physically filled in by the funeral director, page 2 should be detached for use es the		29a. Certifier 1 Certifying Pl	nysician: To the best of my knowledg	e, death occurred at the time, date and place	, and due to the cause	e(s) and manner as stated.
:	To the Hospital of Attending Prystoten: The within 24 hours eiter death. To the Funanal Director: After this certificate he completely filled in by the funeral director, page	Medical	(Check only 2 Medical Examone)	miner: On the basis of examination at and manner stated.	nd/or investigation, in my opinion, death occu	irred at the time, date	and place, and due to the cause(s)
	within 2 To the	Me	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month, Day, Year)
	260		/X LL	MI	UD 1)5072°	5 8	-21-2006
			30 Name and address of persop who	completed cause of death (Item 23a)	(Type, Print)		11
		-	dann for Rio	Linger 8601	leterans Hum 1	1. Warsv.	lle, MD 2/108
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature		11.001001	
	Regist		AUG 2	3 2006 Marie	* Anorth		

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

	Redistrar	rtificate of Death	Reg. No. 2006 2911
Physician/ Medical Examine			2. Date of Death Month Day Year August 27, 2006 3. Time of Death 1333 hrs
	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat	4c. County of Death
Funeral	Prince George's Hospital Center 5. Social Security Number 6. Sex 7. Age (In yrs	ast birthday) If Under 1 Year If Under 24Hr	Prince George's 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
Director	None 1 M 2 X F	Yrs. Months Days Hours Mir	—
any		Town or Location	10d. Inside City Limits
Varyland 28a-f show any 1 at once. ector	MD Prince Georges	Upper Marlboro	1 X Yes 2 No
death with the Maryland or items 23a or 28a-f sho must be notified at once.	13542 Lord Sterling Place	10f. Zip Code 20772	10g. Citizen of What Country? U.S.A.
	11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year	S. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto	o Rican, etc.) White, etc.Black & Asian Pacific
ours aft atural" xamine	or Dates:	16a. Decedent's Usual Occupation (Give kind of	
36 in 72 h han "n lical E	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use rel None	NONE
5-0036 ed within 72 hour lygiene other than "natt the Medical Exar Completed	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Surname)
21215 21215 Duld be file Mental H marked of ic event, tile	Christopher C. Manu 19a. Informant's Name/Relationship (Type, Print)	Xamono	dria T. Fairley
AD 21 2 should h and Me 27 is ma matic ev	Xamondria T.Manu/Mother	113542 Lord Sterlin	Rural Route Number, City or Town, State, Zip Code) 20772 ng Pl.Upper Marlboro, MD
Baltimore, MD 21215-0036 oermit. Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", njury or other traumatic event, the Medical Examiner To Be Completed by	20a. Method of Disposition 20b.	Place of Disposition (Name of cemetery, crematory or other place) Verdale Park Cem 8/	Date 20c. Location - City or Town, State
Baltimc permit. Page Department of Important: injury or oth	4 Donation 5 Other Specify. 21 Signature of Fune (a) Proceedings of Specify.		·
Balt permit. Depart Impor	1/5 C. Saul O		ylor's Funeral Home St.NW Washington,DC 2000
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death failure. List only one cause on each line.	. Do not enter the mode of dying, such as cardiac	or respiratory arrest, shock, or heart Approximate Interval Between Onset and
Examiner	Immediate Cause (Final disease or condition resulting in death) a Sudden Unexplai Due to (or as a consequence or	ned Death in infancy	Death
	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence o	Δ.	
ted Insite	cause. Enter Underlying Cause (Disease or injury that initiated		
cuted nd ransit	events resulting in death) Last Due to (or as a consequence o	f):	
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8760, rithcate be ing physici as the buri	IF FEMALE: 23b. Was decedent pregnant in the		23d. Date of delivery
by the attending rched for use as:	1 Yes 2 No 9 Unknown 9 Unknown		
, P.O. B res that the d signed by the be detached d by Phy	Part II. Other significant conditions contributing to death but not re	esulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
S, P.C quires that an signed ald be det			1 Yes 2 No 3 Probably 4 Unknown
Division of Vital Records, P.O. ral or attending Physician: The law requires that the safter death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach artification: To Be Completed by P			24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
Vital Rec ysician: The l his certificate l director, page	25. Was case referred to medical	26.Place of Death (Check	1 Yes 2 No 1 Yes 2 No
f Vital Physician er this cert ral directo	examiner?	I Other:	ng Home 5 Residence 6 Other:
n of ving Ph. h. After ti funeral	1 Natural 5 Dadies (Month, Day, Year)	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred
ivisior or Attend after death Director: 1 in by the	2 Accident Investigation 28e Place of Injury - At by	Fnd 12:48 pt 1 Yes 2 X No ome, farm, street, factory, office building, etc.	unk 28f. Location (Street and Number or Rural Route Number, City
Division ospital or Attending nours after death. Ineral Director: After filled in by the function: Certification:	4 Homicide determined (Specify) found	in residence	Upper Marlboro, MD Sterling
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi Medical Certification: To Be Completed by Physician/Medical Ex	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination a and manner stated.		d due to the cause(s) and manner as started at the time, date and place, and due to the cause(s)
E B E S	29b. Signature and title of certifier	29c. License number	29d Date signed (Month, Day, Year)
	Work Hillar	O.C.M.E.	August 29, 2006
CR	Name and address of person who completed cause of death (Item Carol Allan, MD	^{123a)} 111 Penn Street, Baltimore, MD 2120	01
State Registra		(male)	
i regiotia	And the same of th		

State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 8:13 p 25. 2006 TERRY JEROME McMAHON August /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) May 4, 195 9. Birthplace (State or Foreign Country)
Washington, DC 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 XM 2□ F 52 1954 215-66-9433 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r then "natural", or Items 23a or 28a-f show the Medical Exarts at must be notified at 1 X Yes 2 No Prince George's Maryland Hyattsville Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20781 U.S.A. 5707 39th Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify Specify: White ģ 3 ☐ Widowed 4 💆 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Automobile Mechanic Scanlon Fleet Service 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 12 should be fi h and Mental h Is marked Mary Burnham James Edward McMahon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2:
Department of Health ar
Importent: If item 27 Is
any injury or other trau 5707 39th Avenue, Hyattsville, Maryland 20781 James E. McMahon - Father 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 □Removal from State Mount Olivet Cemetery 8/29/2006 Washington, DC 4 □ Donation | 5 □ Other (Specify) 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Huneral Service Licensee 4739 Baltimore Ave., Hyattsville, MD 20781 23a. Part N. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Liver Failure **Physician** /Medical Due to (or as a consequence of): Examiner cirrhosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Joseas of Jury that initiated events Due to (or as a consequence of): Examiner Alcoho burial-transit Hepatitis resulting in death) Last Due to (or as a consequence of) Box 68760 Be Completed by Physician/Medical the use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy Month Day Yea in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No o 9 Unknown ے 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed 1 Yes 2 No Vital : After this certification funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1- Inpatient 2 ER/Outpatient 3 DOA ို ō this 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Certification: Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation death. within 24 hours after death To the Funeral Director: completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 9 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifer D58510 ddress of person who completed cause of death (Item 23a) (Type, Print) Stephen 31. Date filed (Month, Day, Year) Registrar's Signature State AUG 2 9 2006 Registrar

Please Type or Print in Black Indelible Ink Dave Contreras Melendez State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day August 25, 2006 Medical Examiner 0453 hrs Dave Contreras Melendez 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Rockville 90 Monroe Street # 212 Montgomery If Under 1 Year | If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) Social Security Number 7. Age (In vrs. last birthday) 9 Birthplace (State or **Funeral** Months Days Hours Director Country) E1 Salvador 1 x M 2 F Nov/25/1941 577-66-8567 64 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 1 X Yes 2 No 28a-f show Rockville notified at once Maryland Montgomery hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20850 U.S.A. 90 Monroe Street # 212 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 10/18/76 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 1 Never Married 2 Married White etc. Yes 2 No If Yes, Give Year 12/5/1974 Yes 2 No specify: Salvadorian Specify: American Indian Examiner þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ permit Pages I and 2 should be filed within 72 P Department of Health and Mental Hygiene. Important: If item 27 is marked other than "injury or other traumatic event, the Medical F Baltimore, MD 21215-0036 12 th Electrician Department of Energy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ana Melendez Daniel Contreras 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (wife) 90 Monroe Street #212 Rockville, MD 20850. Cecilia del Toro 20a Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State Burial 2 X Cremation 3 Removal from State crematory or other place) crematory or other place) INC. Chesapeake Crematory; Beltsville,MD. Sept/7/06 Other Specify Donation 5 22. Name and Address of Facility Santa Cruz Servicios Latinos, INC. 21. Sign ture of Funeral Service/Licenses 600 Kennedy Street NW. Washington, D. C. 20011 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Exami (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last pue Physician/Medical XXUNPENDED AMENDED item#23a.PII.27.perME.g859.9/14/06 TT Box 68760. ing physas as the b IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 🗸 Unknown Fentanyl use Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? certificate ✓ Yes 2 No No ✓ Yes 25 Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other₄ Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other Scene 1 🗸 Yes No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending Yes 2 No the 2 _ Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical within 2 To the I 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 25, 2006 30 Name and address of person who completed cause of death (Item 23a)

State

Registrar

31. Date filed (Month, Day, Year) 7 SEP 0

Carol Allan, MD

Assistant Medical Examiner

ORIGINAL

111 Penn Street, Baltimore, MD 21201

			1 - For State Registrar	State	of Maryla	nd / Depa <i>Cei</i>	artmen	t of H	ealth a	and M	ental Hygi	ene 2 (06	29145	
	Physicia		Decedent's Name (First, Middle Georges Andre	Maurice							2. Date of Death Month	Day	Y006	3. Time of Death 1348 his	
	/Medic Examin		4a. Facility Name (If not institution	-					Location o			4c. County of Death			
		2	Washington Adv 5. Social Security Number	entist H		. last birthday)			If Under:		8. Date of Birth		ntgomery ace (State or Foreign		
	Funeral Director		579-82-6529	1 M 2 □ F	51		Months	Days	Hours	Min	(Month, Day, 1	rea <i>r)</i> 1955	Coun	Haiti	
2			Usual Residence of Decedent												
	show	,	10a. State 10b. County		10c. C	City, Town or Lo	cation						10	0d. Inside City Limits 1 ☐ Yes 2 ☐ No	
	28a-f	Director	Maryland Prince 10e. Street and Number	e George	's	River		Codo			140	Wh - 4 C			
	with with	ם בי					10f. Zip				10	10g. Citizen of What Country?			
	death	Funeral	5713 Silk Tree 11. Marital Status	12. Was De	cedent Ever in I		20737 Was Decedent of Hispanic Origin? (Specify Yes or						ce - Americ		
2	be filed within 72 hours effer death with the Maryland ital Hygiene. I haturall, or items 23a or 28a-f show of other then "natural", or items 23a or 28a-f show event, the Medical Exeminer must be notified at	/Fur	1 123 Never Married 2 ☐ Married 1 ☐ Yes 2 123 No 1 ☐ Yes 2 123 No 5 Pecify:								Rican, etc.)		ck, White, e y: Blac		
3	ural',	d by	3 Widowed 4 Divorced	Year or	Dates:										
2	n 72 n nat	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work life. DO NOT use if							t of workin	ng 1	6b. Kind of B	usiness/Inc	lustry	
7 7	r there	E O	Elementary/Secondary (0-12)	College 4	(1-4or 5+)		Gener						Insur	ance	
2	e filec at Hyg rothe vent,	BeC	17. Father's Name (First, Middle,	Last)					18. Mothe	er's Name	(First, Middle, M.	aiden Sumai	ne)		
2	2 should be filed within and Mental Hygiene is marked other then aumatic event, the Mental is the Mental is a Ment	2	Andre Maurice								e Denis				
=	1 and 2 sh Health and tam 27 is m other traum		19a. Informant's Name/Relations Stephanie Mauri		er						Riverdal				
נים ביים	permit. Pages 1 and 2 should by Department of Health and Menta Importent: If Item 27 is marked any injury or other traumatic evonce.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (S)		1 State	Place of Dispo cemetery, creater tropolita	matory`or o	ther place		Septe	ember 2	Oc. Location			
Dall	permit. Departm Imports any inju		21. Signature of Funeral Service),	s of Facult	ins I	Funeral	Home I	nc.	irginia MD 20901					
			23a. Part1. Enter the disease, or shock, or heart failure. List						ring,	Approximate					
F	Physician		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	Fa	ile	in					Interval Between Onset and Death				
** **:	/Medical Examiner			Due to	o (or as Conse	m he	SI	wc	K						
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(or as a conse	quence of):	200	Pur	aur	non	via.				
Ś	icate be executed physicien and the burial-transit		resulting in death) Last	Due to	(or as a conse	equence of):	ides neep	lin	lore	n Hi	/				
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YOU .	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funneral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ №	□Ectopic pregnancy □ Other (specify)					23d. Date of delivery Month Day Year						
	d by the		9 ☐ Unknown Part II. Other significant condition	9⊟ Unk		esulting in the u	ndoch ing o		o in Dart I		220 Did tobs	200 1100 000	teibuto to th	e cause of death?	
500	quires t	ed by	Clistridia	n diff	rile	Coli	tes	ause give	iii ii i Faiti.	· 	1 🗆 Yes	_/		ably 4 Unknown	
200	e law re has bee	Completed	Dute	Round	fai	lung					24a. Was an autopsy		prior to con	psy findings available inpletion of cause of	
8	n: Thi licete r, pag			1							perform 1 Yes 2	No	death? 1 ☐ Yes	2□ No	
=	sicial certifirecto	o Be	25. Was case referred to medical examiner? 1 Yes 2 BNo	Hospital:	Inpatient 2	TER/Outpot/or		Othe			(Check only one				
5	g Phy er this eral d	ت: ح	27. Manner of Death	28a. Date	of Injury nth, Day Year)	28b. Time o		8c. Injury Work	4 🗆 IVU		ne 5 Resider 28d. Describe hov			")	
5	ath. r: Aft	atio	1 Matural 5 ☐ Pendin 2 ☐ Accident investi	gation	nın, Day rear)	Injury	м		/es 2 □ I	No					
	or Atterder de Director in by the	Certification:	2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Stre City or Town,	et and Num State)	ber or Rura	Route Number,	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C	29a. Certifier 1 Certifyir (Check only one) 2 Medical	nowledge, death	h occurred vestigation	at the tim	e, date an pinion, dea	nd place, a oth occurre	and due to the cau ed at the time, dat	use(s) and m	anner as st	ated. the cause(s)			
29d. Date 47867 87 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) One Y Zuniga, MD 4101 Randoph Rd: #2 State Registrar 31. Date filed (Month, Day, Year) 32 ring/strar's Signature 33 ring/strar's Signature 34 AUG 2 9 2006									d. Date signe	d (Month, I	Day, Year)				
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			30. Name and add ess of person	who completed car	use of death (Ite	em 23a) (Type,	Print)	11-	N 0	A 1	1 : - 1	11 = 41	:0 1	L. L. BAN	
	A		31. Date filed (Month, Day, Year)) Un	ey Zu	niga	MD	71	UI K	and	olph Ro	#216	Kac	Kville,MD	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** September 2006 9:00 <u>Frank Albert Mandart</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlotte Hall St. Mary's Charlotte Hall Veterans Home If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1**∑**M 2□F Months Director 1920 Pennsylvania 86 February 8, 168-14-4716 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahow *naturel', or itama 23a or 28a-f ahov adical Examinar must be notified at Maryland Howard Dayton 1 Yes 2 No Directo the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21036 USA 5019 Morning Star Drive Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: White 3 Twidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) r than Elementary/Secondary (0-12) al Hygiene. College (1-4or 5+) 12 Carpenter Department of Defense of Heelth and Mental Hygie I Item 27 is marked other r other traumatic avant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Campanell Salvatore Mandart 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mandart/Son 5019 Morning Star Drive, Dayton, MD 21036 Ronald 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State September ō = 6 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Depertment of Important: if any injury or once. Brinsfield-Echols Crem. 6, 2006 Charlotte Hall, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., 30195 Three Notch Rd., Charlotte Hall, MD 20622 11/100H1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** lachyarrhuthmia /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Disease Due to (or as a consequence of) Examiner Dilated burial-transit The law requires that the death certificate be executed -Stage omu Due to (or as a consequence of): Box 68760, physicien Physician/Medical pertensive months the th attending IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, **À** pertension monan 1 Yes 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available pnor to completion of cause of death?
1 ☐ Yes 2 ☐ No Disease 24a. Was an maman page 2 autopsy Hypothy certificate roidi 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 🗀 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 No 3 DOA 2 ER/Outpatient this 28a. Date of fnjury (Month, Day Year) Certification: 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. s efter death ii Director: / id in by the f 2 Accident investigation 1 Yes 2 No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗍 Homicide within 24 hours of To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier of death (Item 23a) (Type, Print) 205 Prince Fredrick, MD 20678 HOSpital 31. Date filed (Month, Day, Year) 32. Registrar's Sign State 0 7 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 006 29147 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Sept. Physician Donald Hunter Myers 7:30 p M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Millers Carroll Carroll View Care Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 5-22-1932 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 MM 2□F BERRYVILLE, VA Yrs 74 228-38-3142 Director Usual Residence of Decedent Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 28a-1 shov traumatic event, the Medical Examener must be notified at XXYes 2 No WESTMINISTER **MILLERS** the Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 21157 126 CENTER ST. Items 23a Funeral death permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If Item 27 is marked other then 2 any injury or other traum." 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc 1 ☐ Yes 2001No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SELF EMPLOYED LABORER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be VIOLA MAE FIDDLER JOHN HUNTER MYERS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2237 MORGAN LN. DUNN LORING, VA 22027 BONNIE PINION 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State ROSEDALE CEMETERY 9/9/06 MARTINSBURG, WV 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ROSEDALE FUNERAL HOME 917 CEMETERY RD. MARTINSBURG, WV 25401 23a a 7. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, suck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760 physician Physiclan/Medlcal the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Tes 2 No 3 Probably 4 Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 **X**No 3 DOA 1 Tes this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 the 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 30. Name and Westing 04 32. R State Registrar

			1 - For State Registrar	State of Mar		artment o			ınd Me			2006	29148
	Physici	an	Decedent's Name (First, Middle, Last) DENO. III.		TOUARI					2. Date of Death Month	Day	Year 2006	3. Time of Death
	/Medic Examir		RENO W 4a. Facility Name (If not institution, give s		ICHAEL	4b. City, To	wn, or L	ocation of		Septemb	_	County of Dea	
	- Admin		Vindobona Nursin	g Home		Brad	docl	k Hei	ghts		F	rederi	.ck
	Funeral Director		5. Social Security Number 6. Security Number 220-30-9577	7. Age ((In yrs. last birthday) 87 Yrs.	If Under 1 \ Months D	Year Days	Hours	Min	Date of Birth (Month, Day, ec. 2,	Year) 1918		thplace (State or Foreign ountry) ryland
	yland now		10a. State 10b. County	1	10c. City, Town or Lo	cation						-	10d. Inside City Limits
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920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinat must be notified at once.	by	1 □ Never Married 2 \(\overline{\text{M}} \) Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		fYes, specify 1☐ Yes 2[x		, Mexican, Specify:	, Puerto Ri	fy Yes or No- can, etc.)		Black, Whi	
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lan	uld be Aental Irked c	To Be	Charles Solomon	Michael				Le1a	ah Ca	atherin	e E	Palmer	
Maryland	and 2 should eath and Men n 27 Is marke er traumatic	3	19a. Informant's Name/Relationship (Ty) Mary Ann Norris /	•						Route Number, , Hager	-		Zip Code) cyland 21740
Baltimore,	Pages 1 and of He ant: If item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	20b. Place of Dispo cemetery, crem St.Paul's	natory or othe	r place)	Se	Datept.9,			ation - City or	Town, State Maryland
Balti	permit. Pages Department of Important: If i any injury or o		21. Signature of Fundal Service Licenses 22. Name and Address of Facility 504 Main Str. Ricketts Funeral Home Myersville,										
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The state of	/Medical Examiner	'n		Due to (or as a consequence of): b. Due to (or as a consequence of):									4 months
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rds, P	The law requires that the tite has been signed by thogge 2 should be detache	by	Part II. Other significant conditions con	stributing to death but	not resulting in the u	nderlying caus	se given	in Part I.		23e. Did tob		-/	the cause of death?
900	aw re	piet	Cancer of	prostat	te					24a. Was an		24b. Were a	utopsy findings available
of Vital Record		Completed	Cancer of	Thyre	sid					autopsy perform		death?	completion of cause of 2 No
Viita	Physician: The this certificate ral director, pag	Be	25. Was case referred of medical examiner?	lospital:					of Death	Check on one	3		
o	this al di	. To	1 ☐ Yes 2 ☑ No	1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatien 28b. Time of		Other	4 10 11401	sing Home	d. Describe ho			ecify)
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Div	Hospital or A 24 hours after 25 hours after Funeral Directely filled in by	O	4 Homicide determined	building, etc.						City or Town,			
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	one)	ner: On the best of each manner state	xamination and/or inv	estigation, in	my opir	nion, deatl	d place, and h occurred	at the time, da	ite and p	place, and due	o to the cause(s)
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ORIGINAL

		For State Registrar	State of Ma	ırylan	d / Depa <i>Cer</i>	artmer	t of H	ealth and Death	d Men		ene	006	29149		
Physicia	an	1. Decedent's Name (First, Middle, L Blossom NEUS CH								Date of Death	Day	2006	3. Time of Death 3:05P M		
/Medic Examin		4a. Facility Name (If not institution, g				4b. City.	Town, or	Location of De		igust	4c. County of Death				
	-	Friends Nursin				Sano	ly Sp	ring If Under 24 F							
Funeral Director		5. Social Security Number 6. 059–34–0207	Sex 7. Age 1 ☐ M 2 ☐ F 9		ast birthday) Yrs.	Months		Hours N	Min. Ma	s. B. Date of Birth (Month, Day, Year) 9. Birthplace (State Country) March 31, 1914 Lithuani					
and		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	cation					10d. Inside City Limits				
Maryli	to	MD Montg	omery		ndy Sp						1 Tyes 2 No				
with the	Funeral Director	10e. Street and Number 17350 Quaker L	ane			10f. Zij			10g. Citizen of What Country United State			•			
deeth	nera	11. Marital Status	S. 13. V	Vas Dece	dent of Hi	spanic Origin? n, Mexican, Pu	? (Specify	Yes or No-	14	I. Race - Amer Black, White					
permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Department of Health and Hygiene. Department of Hygiene.	þ	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:					Specify: W			S	Specify: White			
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12 sho h and 7 is ma		19a. Informant's Name/Relationship Michael Neusch										Town, State, Zi	p Code)		
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permit. Departimport any nj											nsky Hebrew Funeral Home 12				
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and the state of t		30. Name and address of person who Christopher J	. Ways, mis	lS	Bill Pri	المال)	P4:11	A 12.	di	107, 6	us	208	32		
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Maryland / Department of Health and Mental Hygiene

Celly Elizabeth N		State of Maryland / Department of Certificate of				_			
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)	Death	2. Date of Dea	Reg. No. 2	0 03.6 me of 2 at 5			
Medical Exami		Kelly Elizabeth Nave		Month August 30	Day Year 0, 2006	0701 hrs			
			b. City, Town, or Location o		4c. County of I				
		Washington County Hospital	Hagerstown		Washingto	on			
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under Months Days Hours			9. Birthplace (State or Foreign			
_n Director		218-82-3940 1 M 2 XF 42 Yrs.	Months Days Hours	Feb 7		Country) Maryland			
*		Usual Residence of Decedent 10a State				10d. Inside City Limits			
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yland P-f sh	호	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?					
e Mar or 28:	Director	354 South Locust Street Apt 2		21740 U.S.A.					
vith the Maryland s 23a or 28a-f show a enotified at once.			Decedent of Hispanic Orig	in? (Specify Yes or N		American Indian, Black,			
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212 ould be Menta mark c even	To Be	Calvin Turner 19a Informant's Name/Relationship (Type, Print) 19b. Mailing	Address (Street and Num		•	State, Zip Code)			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-1 she injury or other traumatic event, the Medical Examiner must be notified at once	-	Brian K. Beachley (Brother) 121	Elm Street I	Hagerstown	Maryland	21740			
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nor ages ent of nt: If	- 1	1 XBurial 2 Cremation 3 Removal from State Rose Hill	Cemetery	9-2-2006	Hagers	stown Maryland			
Baltimore, Dermit. Pages I an Department of He Important: If ite		21. Signature of Funeral Service Licensee 22. N	ame and Address of Facility	Douglas A	Fierv Fi	meral Home			
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Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	e mode of dying, such as ca	ardiac or respiratory ar	rest, shock, or heart	Approximate Interval Between Onset and			
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Division of Vital Records, pital or Attending Physician: The law requirt ours after death. eral Director: After this certificate has been similed in by the funeral director, page 2 should	Certification:	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, stree	t, factory, office building, etc	c. 28f. Location (or Town,		or Rural Route Number, City			
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To with	Mec	and manner stated 29b. Signature and title of certifier	29c. License number		29d. Date signed	(Month, Day, Year)			
		Aluna Brassell, MD.	O.C.M.E.		August 31, 2				
L		30 Name and address of person who completed cause of death (Item 23a)							
4			enn Street, Baltimore	e, MD 21201					
	ate	31. Date filed (MSVE) Pay Year) 2006 32 degistrar's Signature							
Regist	trar	Files B. Son							
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State of Maryland / Department of Health and Mental Hygiene

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Physici edical Exami		1. Decedent's Name (First, Middle,L Wilfredo II.	_{-ast)} -Ortiz - Wil i	fredo H	Jernandez Or	tiz	2. Date of Deat Month August 26		3. Time of Death 0108 hrs
-41	1	4a Facility Name (if not institution,			4b. City, Town, o			4c. County of Death	
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Director		578-33-2394 1 Usual Residence of Decedent	X M 2 F	32	Yrs. Months Day	ys Hours M	^{1n.} 09/02/	/1973 Foreig	n EI ^{untry)} Salvador
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after dea ral", or it	by Fur	3 Widowed 4 Divorce	1 Yes 2 X ced If Yes, Give Year or Dates:		1 X Yes 2 No				ite
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of sel and Menhal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner myst be notified at once	Completed	15. Decedent's Education (Specify Elementary/Secondary (0-12) 3rd	y only highest grade comple College (1-4 or 5+)		Decedent's Usual Occupa during most of working life Carpenter			Carpentr	
21215-0036 und be filed within 7 Mental Hygiene marked other than ic event, the Medica	Com	17. Father's Name (First, Middle, La	ast)			18.Mother's Na	me (First, Middle, N	Maiden Surname)	
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MD 2 d 2 shoul tth and M n 27 is m	ĭ	19a Informant's Name/Relationship Maria Cleta Orti aunt	iz De Reyes		Mailing Address (Stre 3 S. Dupont lmington, D				
Baltimore, MD bernit Pages I and 2 she Department of Health and Important: If item 27 is njury or other traumati		20a Method of Disposition 1 X Burial 2 Cremation	3 Removal from State	cremato	of Disposition (Name of co pry or other place)		Date	20c. Location - City or	
altim mit Pag partment portant		4 Donation 5 Other Speci 21. Sign, ture of Funeral Service Lice		Family	Cemetery 22. Name and Addres		-07-06 H. Bacon	El Salvad	
	8	23a. Part I. Enter the disease, or co	· Bacon	o donth. Do no	3447 14th	Street	, N.W. Wa	ashington,	D.C. 20010
Physician /Medical Examiner		failure. List only one cause on		e death, Do no	it enter the mode or dying	g, such as cardia	correspiratory arre	est, shock, or near	Approximate Interval Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a consequence).	uence of):					
and the second	iner	Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause	Due to (or as a consequ	uence of):					
nted d ansit	Examiner	events resulting in death) Last	Due to (or as a consequent	uence of):					
760, cate be executed physician and the burial - transit	Medical	UNPENDED	X AMENDED 1 p	er me g	3 86 1 11 -29-0	96 vt			
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth Pregnant at tin	2		Ectopic preg	gnancy	23d. Date of delivery Month	Day Year
Box 68 e death certif the attending	Physician	1 Yes 2 No 9 Unkno	own 9 Unknown		0.1107 (1272117)				
, P.O. Box 68. ires that the death certification is signed by the attending to be detached for use as 1	ρ	Part II. Other significant condition	ns contributing to death b	out not resulting	g in the underlying cause	given in Part I.		bacco use contribute to 2 No 3 Prot	
of Vital Records, ng Physician: The law requir ther this certificate has been s meral director, page 2 should I	Completed						24a. Was a autop	sy prior to d	topsy findings available completion of cause of
Rec The la ficate h	E	05 104				()	1 Yes	rmed? death? 2 No 1 Ye	es 2 No
Vital hysician this cert	o Be	25. Was case referred to medical examiner?	Hospital 1 Inpatient	2 ER/O	utpatient 3 DOA	Other Nur		Residence 6 🗸 Other	: Scene
ision of Vital Rec Attending Physician: The r death ector: After this certificate by the funeral director, page	-	27. Manner of Death 1 Natural 5 Pendin		28b. 1 0107	7 h	ury at Work? Yes 2 ✔ No	I=	now injury occurred struck by auto	
. ≥ º º º º º º º	Certification:	2 Accident Investig 3 Suicide 6 Could r 4 Homicide	not be 28e. Place of Injur		arm, street, factory, office	building, etc.	or Town, S		ral Route Number, City venue, Silver Sprin
the llos the Fun the Fun	Medical C	29a Certifier 1 Certifying Phys	sician: To the best of my k						
	Me	29b. Signature and title of certifier	and manner stated			ise number		29d Date signed (Mo	nth, Day, Year)
1)	30 Name and address of person w	the completed cause of des	ath (Item 23a)	0.0	:.M.E.		August 26, 2006	
SP		Margarita Korell MD.	Assistant Medical E	xaminer	111 Penn Street, f	Baltimore, MI	D 21201		
S Regis	tate	AUG 3 1 2006	32. Registrar's	Signature					

			Please T 1 - State Registrer	State of Ma			nt of H	lealth and M	Jental Hy	niene	gible.	29152	
	Dhysisi	an l	Registrer 1. Decedent's Name (First, Middle, Last)			Certifica	le UI	Death	2. Date of Dea	ath Day	Year	3. Time of Death	
	Physici /Medio		Harry Walter C						Augus			0716"	
	Examir	er	4a. Facility Name (If not institution, give	street and number)	EAS			STON			Albo	+	
	Funeral		Memorial Hos 5. Social Security Number 6. Sex	7. Ag	e (In yrs. last bir	thday) If Und	er 1 Year	If Under 24 Hrs.	8. Date of Birt (Month, Da				
,	Director		057-05-7822	M 2□F	95	Yrs. Months	Days	Hours Min.	May 5,			York	
3	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other then "netural", or items 23a or 28a-1 show important: if item 27 is marked other then "netural", or items 23a or 28a-1 show important; if item 27 is marked to the traumatic event, ir a Medical Examinar must be notified at ance.	or	10a. State 10b. County Maryland Talb	ont	10c. City, Tow	n or Location		Easton		-		10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
JR.	28a-	rect	10e. Street and Number			10f. Z	ip Code	<u> </u>		10g. Citizer	n of What Cou	intry?	
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ONNOR	r dea	Funeral Director	THE THE STATE OF T	12. Was Decedent Armed Forces?		13. Was Dec If Yes, sp	edent of H ecify Cubi	lispanic Origin? (Si an, Mexican, Puert	pecify Yes or No Rican, etc.)	- 14.	Race - Ameri Black, White		
36	rs after I', or ite	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 ∰Yes 2 ☐ If If Yes, Give Year or Dates:	wwII	1 🗆 Yes	2 No	Specify:		Sp	oecify:		
	2 hou	ted	15. Decedent's Edu	cation		Decedent's Us	ual Occup	pation during most of word d)	kina	16b. Kind	whi i of Business/Ir		
20.2	within 72 hours ene. then "netural", te Medical Exa	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	5+)				Kiilig	T	-	L	
~ ~ ~	iled w Hygier Ither th		17. Father's Name (First, Middle, Last)	7		Stock B	roke	18. Mother's Nam	ne (First Middle		estment	<u> </u>	
and	d be f	To Be	Harry L. O'Connor						Grace		,		
f C anyland	shoul	۲	19a. Informant's Name/Relationship (Ty	pe, Print)	196	Mailing Addre	ss (Street	and Number or Ru	ral Route Numbe	er, City or T	own, State, Zi	ip Code)	
∠ ≥	and 2 salth a n 27 io		Elizabeth Tong/P.	R.				s Neck Ro					
+ARR Baltimore,	permit. Pages 1 and 2 should be filed within Depertment of Health and Mental Hygiene importent: If item 27 is marked other then 's hy injury or other traumatic event, ILa Ma once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R	temoval from State	cemete	f Disposition (Nary, crematory or	other pla		Date		tion - City or T		
A. Itim	it. Partiment rtent: njury		4 □ Donation 5 □ Other (Specify) 2	00	ritasno			Center 8/			ambrida	,	
上 Ba	Depermine on its poor		Mond Attach	1- Den	nuell	Mid S 2272	hore Huds	Crematic on Rd., C	n Cente	r, P.	0. Box	1464,	
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	/Medical Examiner		resulting in death)		a consequence						i		
		je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	of):					-		
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60,	be exe icien a burial-	al Ex	resulting in death) cast	Due to (or as	a consequence	of):							
687	ficate physics the l			d									
Box (n certifi anding use a	M/u	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome	of pregnancy 2 Petal death	3 □Ectopic	nregnago	v		230	d. Date of delik	•	
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	that the	by Ph	Part II. Other significant conditions con	ntributing to death b	ut not resulting i	n the underlying	cause gn	ven in Part I.	23e. Did t	obacco use	contribute to	the cause of death?	
rds	equires en sign								1 🗆 '	Yes 2 🗹	No 3□Pro	bably 4 [Unknown	
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_	To the Hospital or Attending Physicien: The law requires that the death certificate within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be deteched for use as the	Medicai C	29a. Certifier 1 Certifying Phy (Cneck only onl) 2 Medical Exami	sicien: To the best ner: On the basis o and manner st	t examination ar	e, death occurre nd/or investigation	d at the ti	ime, date and place opinion, death occu	, and due to the irred at the time,	cause(s) ar date and pi	nd manner as lace, and due	stated, to the cause(s)	
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	F 5 F Ö		I foliabetres				DOU	99487		8/2	7/200	6	
			30. Name od address of person who co							,	1		
_			Dr. John Botsis,			on Stre	et,	Easton, M	ID 21601				
	St. Regist	ate	31. Date filed (Month, Day, Year)	2006	ar's Signature	t de	D						

DIVISION OF VITAL RECORDS, P.O. BOX 68/60,)
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within 24 nours effet dearn. To the Funerel Director: After this certificate hes been signed by the attending physicien and	
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Second Prince P	olace (State or Foreign
Social Security Number 6. Sex 10. May 2 7. Age (In yrs. last birthday) 10. Under 1 Year 11. Under 1 Year 11. Under 1 Year 11. Under 2 Hrs. 8. Date of Birth (Months Days Hours Min. April 13, 1963 9. Birth (Months Days Months Days Hours Min. April 13, 1963 9. Birth (Months Days Months Days	olace (State or Foreign
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23a. Part1. Enter the disease, or complications that caused line death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	
23a. Part1. Enter the disease, or complications that caused line death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	
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23a. Part1. Enter the disease, or complications that caused line death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	
23a. Part1. Enter the disease, or complications that caused line death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) AIDS Due to (or as a consequence of): End Stage Renal Disease Due to (or as a consequence of):	20747
Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Belween
/Medical resulting in death) Due to (or as a consequence of): End Stage Renal Disease Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):	Onset and Death
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FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at lime of death 5 Other (specify) 9 Unknown	
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ti ya yu a nukuowu	Day Year
E B B Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to	the cause of death?
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Hypertension, Liver Cirrhosis 1 Yes 2 No 3 Pro	opsy findings available ompletion of cause of
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25. Was case referred to medical examiner? 1	2□ No
27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28d. Describe how injury occurred	
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27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 5 Pending investigation 5 Pending investigation 6 Could not be determined 5 Pending investigation 6 City or Town, State) 28a. Date of Injury 28b. Time of Injury Work? 1 Yes 2 No 28b. Time of Injury Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred work?	
	(v)
29a. Certifier Check only one 29b. Signature and title of certifier 29d. Date signed (Month, 1965) 29c. License number 29d. Date signed (Month, 1965) 29	fy) al Route Number,
29c. License number 29d. Date signed (Month)	fy) al Route Number, stated.
D002208 8/29/10	ral Route Number, stated. to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. M. Zonozi 1320 Southern Ave., SE Washington, DC 20032	al Route Number, stated. to the cause(s) Day, Year)
	al Route Number, stated. to the cause(s) Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month ^{Day} 2006 Basilio В. Pimentil August 27, 10:20 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Center Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Yea March 2, 192 6. Sex **Funeral** 9. Birthplece (State or Foreign XX M 2 F Philippines Director 586-60-4149 83 Usual Residence of Decedent deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Heelth and Mental Hyglene. Importent: If Item 27 le marked other than "naturel", or Iteme 23a or 28a-f ehow any injury or other traumatic event, Ita Mudical Examinat mual be notified at once. 10d. Inside City Limits Director 1 Yes XXXNo Maryland Prince George's Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 902 Tuckaway Terrace 20744 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 1969 11. Marital Status Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: Filipino ፩ If Yes, Give Year or Dates: Retired 3 X Widowed 4 □ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Steward U.S. Navy Military 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Regino Pimentil Balbuena Angelita 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) May Sarmiento / Daughter 8906 Ft. Foote Road Ft. Washington, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XXBurial 2 ☐ Cremation 3 ☐ Removal from State 09/11/2006 4 □ Donation 5 □ Other (Specify) Arlington Nat. Cemetery Arlington, Virginia 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signature of uneral Service Licensee 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause/or each line. Approximate Intervat Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) **Physician** End-Stage VALUULAR KENT DISEASE ears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: Atler this certificate has been signed by the eltending physicien and completely filled in by the funeral director, page 2 should be detected for use as the burial-transit completely filled in by the funeral director, page 2 should be detected for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 0 0750 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner?
1 Yes 2 No Certification: To Be 26. Place of Death Check only one Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) H 0 SP (CC 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident М 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) 4 🗌 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 025205 HUGUST 27,2006 no 30. Name and address of person who completed caule death (Item 23a) (Type, Print) A.Rilon 6701 N. Charles St. Balts. md 21204 6 BMC 31. Date filed (Month, Day, Year) State Registrar AUG 2 9 2006

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Mable Helena Poynter 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day August 23, 2006 Mabel Helena Poynter 1603 hrs Medical Examiner c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Prince Georges Hospital Center Cheverly 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Social Security Number If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) **Funeral** 305-24-9080 Months Days Hours Min. 79 Director Oct 12, 1926 Country) Indiana M 2XF Yrs Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location any. 10a State 10h County 1 X Yes 2 No f show Anne Arundel Linthicum Maryland death with the Maryland Director 10f Zip Code 10g. Citizen of What Country 28a-f 10e. Street and Numbe 619 Shipley Road 21090 USA items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funera 12. Was Decedent Ever in U.S. must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' 1 Never Married 2 XMarried Yes 2 X No White f Yes, Give Year Yes 2x No specify: Specify 2 should be filed within 72 hours after Widowed Divorced ð 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) tem 27 is marked other than traumatic event, the Medical 21215-0036 12th Homemaker Private ges I and 2 should be filed within of Health and Mental Hygiene.

If item 27 is marked other th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cordia Storey Ray S. Harshbargar Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 619 Shipley Road, Linthicum, MD 21090 Baltimore, MD (Husband) James Poynter 20c. Location - City or Town, State Date 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State Department o 8/30/2006 Beltsville, MD Chesapeake Crematory Donation Other Specify 10 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Road, Lanham, MD 20706 fications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva Physician Between Onset and failure. List only one cause of /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine Due to (or as a consequence of) events resulting in death) Last - transit /sician/Medical AMENDED UNPENDED the attending physician ed for use as the burial Box 68760, 23d Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day 3 Ectopic pregnancy Year Live birth Fetal death Month past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? ant conditions contributing to death but not resulting in the underlying cause given in Part I 1 Yes 2 V No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available

Division of Vital Records, P.O. fo the Hospital or Attending Physician: After this within 24 hours after death.

To the Funeral Director:

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					autopsy performed? 1 ✓ Yes 2 No	prior to compl death? 1 Yes	letion of cause of
25. Was case referred to medical			26.Place	e of Death (Check	only one)		
examiner? 1 ✓ Yes 2 No	spital: 1 Inpatient 2	ER/Outpatient 3	ng Home 5 Residence 6 Other:				
27. Manner of Death 1 Natural 5 Pending 2 ✓ Accident Investigation	28a. Date of Injury (Month, Day Year) Aug 23, 2006	28b. Time of Injury 1342 hrs	1	iry at Work? Yes 2 ✔ No	28d. Describe how injury Passenger auto au		
3 Suicide 6 Could not be determined	28e. Place of Injury - At he	ome, farm, street, facto d / Highway	28f. Location (Street and or Town, State) N/B Rt.4 and H.D.				
29a. Certifier 1 Certifying Physician (Check only one) 2 Medical Examiner: C	n: To the best of my knowled On the basis of examination a	lge, death occurred at and/or investigation, in	the time, d my opinio	ate and place, an n, death occurred	d due to the cause(s) and at the time, date and place	manner as started e, and due to the cau	use(s)

O

Certification:

Medical

29b

30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner

and manner stated

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

August 25, 2006

31 Date filed (Month, Day Year) State 8 2086 Registra

Signature and title of certifier

32 Registrar's Signature

			For Stata Ragistrar	State of Maryla	•	artment of I		Mental Hy	giene Rag. No.	006	29156	
	Physici /Medio	ai	1. Decedent's Name (First, Middle, La PATRICIA L	ROBERTS	-	At Ch. Tour			eath Day 27, 2	Year 006	3. Time of Death 7:30 PM	
	Examin Funeral	er	4a. Facility Name (If not institution, gine FT. WASHINGTON 5. Social Security Number 6.	HEALTH & REHA	B.	FT. WAS		8. Date of B	PR	Ounty of Death INCE GE 9. Birth	ORGE	
	Director		577-50-6363 Usual Residence of Decedent	1□M XOF 69	Yrs.	Months Days	Hours Min.	9-14-	36	WASH	I., DC	
	the Maryland 28e-f show	Director	MD 10b. County PRINCE 10e. Street and Number		City, Town or Lo				10g Citize	en of What Cou	10d. Inside City Limits 1 X Yes 2 □ No	
	with pe or		9205 PEEBLE COU	рт		2074	11		_		artity :	
920	hours after death ' urel', or Items 23	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates:			Hispanic Origin? (S pan, Mexican, Puer	Specify Yes or N to Rican, etc.)	0- 14	U. S. A. 14. Race - American Indian, Black, White, etc. Specify: BLACK		
215-0	inel	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation rade completed) College (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of wo	nking	16b. Kin	d of Business/li	ndustry	
Maryland 21215-0036	be filed within tal Hygiene. od other than event, Ira M	Be	11TH GRADE 17. Father's Name (First, Middle, Las		ME1	DICAL CLI	18. Mother's Na	me (First, Middle	e, Maiden S		ETH'S HOSP.	
ryla	id 2 should be tth and Mental 27 is marked o	ဥ	LEANORD WRIGHT, 19a. Informant's Name/Relationship		19b Mailie	na Addrose (Stroe	JUAN 1T			Tourn State 7	in Code)	
Ma	aith an 27 is or treur		,	IT-DAUGHTER			OURT FT					
Baltimore,	a 9 E 5		20a. Method of Disposition 1 X Burial 2 Cremation 3 (4 Donation 5 Other (Special Control of Cont	Removal from State	ENWOOD	matory or other pla CEMETERY	9-2		WASH1	ation - City or T	DC	
Balti	permit. Pages 1 Department of H Importent: If ite any injury or ott		21. Signature of Funeral Service Lice	nsee Pricks			ess of Facility P				NERAL HOME	
	Physician /Medical		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	nplications that caused the dy one cause on each line. a. ARTERIOSCI Due to (or as a cons	EROT1C				arrest,	,	Approximate Interval Between Onset and Death VEARS	
8760,	rate be executed rate this interest in the purial-transit rate in the puria	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. HYPERTENS: Due to (or as a con: Due to (or as a con:	sequence of):						YEARS	
P.O. Box 6	t the death certific by the attending p ached for use as	Physician/Med	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 XXo 9 Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of	etal death 3	□Ectopic pregnand □ Other (specify)	су		23	23d. Date of delivery Month Day		
	uires tha signed I d be det	۵	Part II. Other significant conditions CONGESTIVE HEAT	-	resulting in the u	inderlying cause g	iven in Part I.		tobacco us		the cause of death?	
Division of Vital Records,	The law ate has b page 2 sl	Completed						24a. Wa auto peri 1 Yes	opsy formed?	24b. Were aut prior to c death? 1 \(\subseteq \text{Yes}	topsy findings available completion of cause of	
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				ath (Check only				
on of	ing Phys After this uneral di	tion: To	1 Yes XXVo 27. Manner of Death 1XXVatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	2 ER/Outpatier 28b. Time o	of 28c. Inju	4 ZQ Nursing	Home 5 Res			ufy) -	
Divisi	el or Attendi s after death. I Director: A id in by the fu	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of City or Town, State)									
	To the Hospitel or a within 24 hours after Yo the Funerel Dire completely filled in b	edical	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	To the To the comple	ž	29b. Signature and the of certifier	8 4			nse number			signed (Month		
	(8)		0000	renglon			32800		AUG.	29, 20	U 6	
	JC		30. Name and address of person who H. HERBERT WASH	INGTON, M. D.	11701 L		ON RD SUI	TE 205 1	FT. WA	SH., M	D 20744	
	Sta Regist		AUG 3 0 2006	32. Registrar's S	guature							

DHMH 17 Rev 1/2001

			1 = For State Registrar AVEND#18per1		-	•	artment of H		and M			2006	29157
	Physici	an	1. Decedent's Name (First, Middle,	,						2. Date of Dea Month	Day		3. Time of Death
	/Medic	al	Frank F. Robe		l		45 Ch. Tana	1		August			8:50 P M
	Examin	er	4a. Facility Name (If not institution, Manor Care Pote		er)		4b. City, Town, or Potomac	Location o	Death			County of Death	7
-	-				Age (In yrs. Jast i	birthday)	If Under 1 Year	If Under 2	24 Hrs.	8. Date of Birt	h	ntgomery	Nace (State or Foreign
н	Funeral Director		710-10-5896	1∰M 2□F	Age (In yrs. Jast 1	Yrs.	Months Days	Hours	Min.	(Month, Day	v. Year)	915 Miss	ntry)
	ס		Usual Residence of Decedent										
	be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "natural", or iteme 23a or 28a-f show other. The Medical Exertinal remail he notified at	ō	MD 10b. County Montgo:	nery	10c. City, To	hesc						1	0d. Inside City Limits 1 X Yes 2 □ No
	28a-f	Director	10e. Street and Number				10f. Zip Code				10a. Citiz	zen of What Cour	ntry?
	3a or		7306 Arrowood 1	Road			20817				USA		,
	death	Funeral	11. Marital Status	12. Was Decede Amed Force		13.	Was Decedent of Hi f Yes, specify Cuba	spanic Orig	gin? (Spe	cify Yes or No-		4. Race - Americ	
ဖွ	after or Ite	Ē	1 Never Married 2 Marrie	d 121 Yes 2	_No 1944-	- 1	r ves, speciny Cuba 1 □ Yes 2 🛣 No	Specify:	i, Puerio r	rican, etc.)		Black, White, Specify: White	
21215-0036	urel',	d by	3 Widowed 4 ☐ Divorced	Year or Date									
15-	n 72	Completed	15. Decedent's (Specify only highest	grade completed)		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	turina most	t of working	ng	16b. Kir	nd of Business/In	dustry
212	within ilene. r then "	E O	Elementary/Secondary (0-12)	College (1-4d 5+	or 5+)	awye		,			La	w Firm	
-	e filed other vent.	BeC	17. Father's Name (First, Middle, La					18. Mothe		(First, Middle,	Maiden .	Sumame)	
ylaı	should be ind Mental marked o urnatic eve	၂၀၂	Frank Roberson						су ₩3	Liliams	-		
Maryland	to the		19a. Informant's Name/Relationshi Robert Elliott/Bu	o (Type, Print) 111 isiness Pa	rtner 7		ng Address (Street a Hackamore						Code)
Baltimore,	s 1 en if Heal item 2 other		20a. Method of Disposition			of Dispo	sition (Name of natory or other place	a)	D	ate	20c. Loc	cation - City or To	own, State
mo	Page nent o int: if		1 ☐ Burial 2 ⚠ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		ua !	-	Crematory		8/30/	2006	Fall	s Church	, VA
alti	apertu apertu nporte ny inju		21. Signature of Funeral Service Li	censee			Name and Addres						
4	8055a	Ш	W. Cutty	1 /4 suno	ref.		30 Wiscon					ngton, I	
E			23a. Part1. Enter the disease, or o shock, or heart lailure. List	omplications that cause on each	sed the death. D h/line.	o not ent	er the mode of dying	g, such as	cardiac oi	r respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)				Ischemia	1					
	Examiner			Due to (or	as a consequenc	ce oi):							
		Jer	Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	as a consequenc	sa of):							
	cuted nd ransit	Examiner	that initiated events	c									
8760,	ate be executed physicien and the burial-transit	Ĕ	resulting in death) Last	Due to (or	as a consequenc	ce of):							
876	physic physic s the b	dica	•	d									
9 x c	eath certific ettending p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						_	2	3d. Date of delive	erv.
Вох	death death	ciar	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnan	n 2 ☐ Fetal dea t at time of death		Ectopic pregnancy Other (specify)					Month	Day Year
P.O.	by the detached	hys	9 Unknown	9□ Unknowr	n								
S, F	as the gned be de	þ	Part II. Other significant condition	s contributing to deat	h but not resulting	g in the u	nderlying cause give	en in Part I.			_	_	ne cause of death?
brd	w e uir b en si st uld l	ted								1 \	es 28	No 3∐Prot	pably 4 □Unknown
Records,	aw as b	Completed								24a. Was autop	sy	prior to co	psy findings available mpletion of cause of
_	r: The licete he										rmed? 2000No	death?	2 □ No
Vital	sicien: Th certificete irector, pag	Be	25. Was case referred to medical examiner? 1 Yes 244 No	Hospital:	all co	0	ot all DOA Othe			(Check only o		. Пон и	
ō	ig Phys ter this neral di	7: To	27 Manner of Death	28a. Date of I	atient 2 ER/	. Time o	IL SEL DON	464140		18d. Describe h		Other (Special occurred	у)
ion	5 2 2 3	atio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investiga		Day Year)	Injury		<br Yes 2 □ l	No				
Division	2 2 2 2	Certification:	3 Suicide 6 Could no 4 Homicide determin	ed 286. Place of	Injury - At home, etc. (Specify)	farm, str	eet, factory, office		2	281. Location (5 City or Tox	Street and vn, State)	d Number or Rura	al Route Number,
	pital		29a. Certifier 1 X Certifying	Physician: To the be	ast of my knowled	ine dos	h accurred at the time	a data a-	d place	and due to the	cancolo,	and manner as =	tated
	To the Hospital or Attenwithin 24 hours efter deatl To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical E.	xaminer: On the basi and manner	s of examination	and/or in	vestigation, in my op	oinion, deal	th occurre	ed at the time,	date and	place, and due to	tated. the cause(s)
	To the within 2 To the complet	Ň	29b. Signature and title of certifier	D			29c. License D0057					e signed (Month,	
	5		h	noy	as, 1	4 13	50037	-4T			8	1271	0 6
- 1	_		30. Name and address of person w				-						
			Truong Bao MD 9					Rockv	ville	, MD 20	850		
3.	Sta Registi		AUG 2 9	2006	istrar's Signature	B	arte						

State of Maryland / Department of Health and Mental Hygiene 2005 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** August 27, 2006 5:30 Evelyn L. Raynor /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Charles County Nursing & Rehab. La Plata Charles If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Pay, Year) 1926 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2X)F Yrs. Washington DC 579-28-2743 Director 79 Usual Residence of Decedent e filed within 72 hours after death with the Maryland at Hygiene.
other then "natural", or itams 23s or 28s-f ehow 10a State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or itams 23s or 28s-f show other treumatic event, the Modical Examinar most be notified at 1 ☐ Yes X☐ No Marvland Charles Marbury Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 4930 Pisgah Marbury Road 20658 US Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No δ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 9 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: if item 27 is marked other eny liury or other treumatic event, 20cs. 17. Father's Name (First, Middle, Last) Be Claude Soper Marie Sanders ဨ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pat Holland - Daughter 1102 Cambridge Drive, Waldorf, MD 20602 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State tX☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Trinity Memorial Gdns 8-30-2006 Waldorf, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Service Licensee 22. Name and Address of Facility M01391 3035 Old Washington Rd. POB 156, Waldorf, MD 20604 Huntt Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** neime resulting in death) /Medical Due to (or as a consequence of) Examiner Due to (or M a consequence of) Sequentially list conditions, if any, leading to immediate cause (Disease or injury Examiner The law requires that the death certificate be executed the attending physicien and the for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) 9 Unknown 9 Unknowń signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 X No 3 Probably 4 □Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificete 1 Yes 2 No 26. Place of Death (Check only one Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient Other: 4 Wursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No ٩ 2 ☐ ER/Outpatient 3 ☐ DOA this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 2 Accident 5 ☐ Pending 1 □ Yes 2 □ No death. investigation M after death 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide To the Hospital or A within 24 hours after To the Funeral Direct determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D55455 30. Nam and a re s of person who completed cause of death (Item 23a) (Type, Print) Fatima Y. Hussein, MD, 5625 Allentown Road, Suite 101, Camp Springs, MD 20746 31. Date filed (Month, Day, Year) 32. Refistrar's Signature State AUG 2 9 2006 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2005 1 - For Stete Ragistrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician 6:15 A Reynolds SRAT 03 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Medical Center ty Maryland University of If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Month Day, Year) MAR . 29, 1963 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🗓 F DELAWARE 43 222-46-5473 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at SUSSEX MILTON 1 Yes 2 No DE Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 19968 USA 23586 SPLINTER LANE Funeral permit. Pages 1 and 2 should be filed within 72 hours after dea. Department of Heelth and Mental Hyglene. Important: If item 27 ie marked other than "natural" or the fraumatic even. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🃉 No If Yes, Give Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify. WHITE Completed by If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ROBERT FIELD BETTY HOLLIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) REYNOLDS-HUSBAND 23586 SPLINTER LANE, MILTON, DE 19968 RANDAL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 20c. Location - City or Town, State ODD FELLOWS CEM. 9-8-06 MILTON, DE 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SHORT FUNERAL SERVICES 416 FEDERAL ST., MILTON, DE 19968 23a. Part1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Alveol **Physician** seeks /Medical Examiner tomega louiru Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ed by the ettending physicien and detached for use as the burial-transit The law requires that the death certificate be executed cuta Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav 4 Pregnant at time of death 5 Other (specify) certificete has been signed by rector, page 2 should be detact Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 10 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2ENO 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗓 No 1 Inpatient 2 ER/Outpatrent 3□ DOA After this 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Hatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a. Certifier 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. To the f Fo the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AU4176435 Z16715 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore City, MD 2170 79 S. Greene

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

SEP 1 3 2006

		•	For State Registrar	State of M	larylan			nt of H te of L		nd M		iene,	2006	29160
	Physici	_	1. Decedent's Name (First, Middle, Las Betty J. Rossier	t)							2. Date of Dear	Day	7 2000%	3. Time of Death 7:25 A.M.
	/Medio Examin		4a. Facility Name (If not institution, give Baltimore Washing			ntor		, Town, or en Bu	Location of			4c.	County of Deat	
	Funeral Director	4	5. Social Security Number 6. Se 577-34-2744			last birthday) Yrs.		r 1 Year	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day 10-14-1	1		thplace (State or Foreign
	h the Maryland ir 28e-f ahow	Irector	Usual Residence of Decedent 10a. State 10b. County	undel	10c. Cit	ty, Town or Lo	wate	r p Code			1	0g. Citiz	zen of What Co	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
9036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28e-f ahow or other traumatic avant, the Medical Examinal routine maillised at	d by Funeral Director	3545 Oak Drive 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Yes 2 I If Yes, Give X Year or Dates	? No		If Yes, sp	ecify Cuba 2 X No	spanic Orig n, Mexican, Specify:	jin? (Spe , Puerto F	cify Yes or No- Rican, etc.)		USA 14. Race - Ame Black, Whit Specify: WI	e, etc. nite
21215-	d within 72 glene. or than "nat	Completed by	15. Decedent's Ed (Specify only highest grades) Elementary/Secondary (0-12) 9th		5+)	_	kind of w DO NOT Iomen	ork done d use retired,	luring most)	of workin	9		Home	industry
yland	should be file and Mental Hyg marked othe umatic avant,	To Be C	17. Father's Name (First, Middle, Last) Wheeler Gree	n							(First, Middle, S	Maiden .	Sumame)	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 sho Department of Health and Important: If Itam 27 Ia m any injury or other traum QDCB.		19a. Informant's Name/Relationship (7) George H. Rossie 20a. Method of Disposition 1 \(\tilde{\text{M}} \) Burial 2 \(\text{Cremation} \) 3 \(\text{J} \) 4 \(\text{Donation} \) 5 \(\text{Other (Specify} \)	r/ Husban	20b. F	1	Oak	Driv	e, Ed	lgewa		210 20c. Lo	037 cation - City or	
Baltir	permit. P Departme traportan any injur.		21. Signature of Fuheral Service-Licen			2	2. Name	and Addres			_	Ka1a	as Fune	ral Home MD 21037
8760,	death certificate be executed Reflection and with the service of	dicai Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, I say, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or a d.	s a consec	quence of):	2_							Interval Between Onset and Death
P.O. Box 68	the death certif y the ettending ched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Feta	al death 3	⊒Ectopic ⊒ Other (pregnancy specify)				2	23d. Date of de Month	livery Day Year
	8	<u>주</u>	Part II. Other significant conditions of	ontributing to death	but not res	sulting in the u	inderlying	cause give	en in Part I.		23e. Did to		A	o the cause of death?
Division of Vital Records,	The law ate has t page 2 s	Completed									24a. Was a autope perfor 1 Yes	iy .	prior to death?	utopsy findings available completion of cause of
f Vita	Physicien: T this certificate ral director, pa	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpa	tient 2] ER/Outpatie	nt 3 🗆 [Othe Othe	er.		(Check only or ne 5 ☐ Resid		S □Other (Spe	ocify)
sion of	Attending Ph r death. setor: After th by the funeral	Certification: 7	27. Magner of Death 1 SNatural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28a. / ate of In Month, E	jury lay Year)	28b. Time of Injury	М		vat ⟨? Yes 2 □N	No	8d. Describe h			
DİVİ	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	ai Certifi	4 Homicide determined	28e. Place of I	etc. (Speci	fy)			ne date and		City or Tow	n, State,)	ural Route Number,
	the Hos in 24 ho the Fun pletely	edic	(Check only 2 Medical Exam	niner: On the basis and manner	of examina	ation and/or in	rvestigatio	n, in my op	pinion, deat	th occurre	ed at the time, d	ate and	place, and due	e to the cause(s)
	To the I	Σ	29b. Signature and title of certifier	790			2	D4		7		1.	e signed (Moni	^
	5		and meter	completed cause of	HUSE	ital S	Print)	2,6	den	Bur	une M	0	. 21d	/
	Sta Regist		31. Date filed (Month, Day, Year)	R	trar's Sigo	ature /	Page !!	Ð						

ORIGINAL

			For State Registrar	State of M	aryland / Depa	artment of F			giene 2006	5 29161
ı	Physicia	an	Decedent's Name (First, Middle EMMET		CHI I TVAN			2. Date of Dea Month	Day Yea 2, 2006	3. Time of Death 11:05pm M
	/Medic		4a. Facility Name (If not institution,	A . give street and number)	SULLIVAN	4b. City, Town, o	r Location of Death	1	4c. County of De	
	Examin	er	Riderwood SNF	,		Silver			Montgome	ry
	Funeral Director		5. Social Security Number 577–48–4912	6. Sex 7. Ag	ge (In yrs. last birthday) 90 ^{Yrs.}	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day April 3	y, Year) 9. B	tirthplace (State or Foreign Country) Iississippi
	show	J.	Usual Residence of Decedent 10a. State 10b. County D • C •		10c. City, Town or Lo					10d. Inside City Limits 1X☐ Yes 2 ☐ No
	28a-f	Director	10e. Street and Number			10f. Zîp Code			10g. Citizen of What	Country?
	3a or	i Di	1810 Redbud Lan	e, N.W.		20012		1	U.S.A.	
350	s 1 and 2 should be tiled within 72 hours after death with free maryland. If Health and Menlard Hygiene. If Health and Menlard Hygiene. I file may 1's marked other than "natural", or Items 23a or 28a-1 show other traumatic event, it a Madical Examilitational be notified.	by Funeral	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Decedent Amed Forces ed 1 Yes 2 1 If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2X No	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Ar Black, Wi Specify: B1	
5	72 hou natura lical E		15. Decedent (Specify only highes	's Education	16a. Dece	dent's Usual Occup	pation during most of work	kina	16b. Kind of Busines	ss/Industry
9500-61212	hen "r	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		during most of world)	_		of Columbia
N	Hygier Hygier Sther to		17. Father's Name (First, Middle,	lyr Last)	POLI	ce Offic			Overnment Maiden Sumame)	
	ld be ental ked o ic eve	To Be	Luther Sullivan				Cora Rob	inson		
Mar	and 2 should be lealth and Mental m 27 is marked of her traumatic ev	-	19a. Informant's Name/Relationsf						or, City or Town, State	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other ODCE.		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S)	3 □Removal from State	20b. Place of Disponentery, cre	osition (Name of matory or other pla	сө)	Date	20c. Location - City	or Town, State
	mit. Prontme oortan injur		21. Sign top of Fun 1 Serve	Licensee	Lincoln M	em. Cem. 2. Name and Addre		2, 2000	Suitland, WDC	20011
ă	Der Tree			>>					6 Kennedy	
1	nysician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	~ Nth	the death. Do not enne. LISC/LIOT s a consequence of):	ter the mode of dy		or respiratory ar		Approximate Interval Between Onset and Death
60,	ate be executed was bysician and he burial-transit and	Ical Examiner	Sequentially list conditions, if any, leading to immediate the control of the con	c	s a consequence of):					
ñ	death certifics e attending pt id for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3	□Ectopic pregnanc □ Other (specify)	у		23d. Date of o Month	delivery Day Year
ds, P.	requires that the de leen signed by the a hould be detached f	by	Part II. Other significant condition	ons contributing to death	but not resulting in the i	underlying cause gr	ven in Part I.			to the cause of death? Probably 4 Unknown
ပ္မ	elaw hasb ge2s	Completed		-				24a. Was autop perfo 1 Yes	rmed? prior to death	
	ician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only o	-24	
ō	ng Phys fter this ineral di	၉	1 Yes 2X No 27. Manner of Death 1X Natural 5 Pendin			of 28c. Inju	ry at rk?		dence 6 Other (S	pecify)
\equiv	or Attendent ifter deatl Director: in by the	Certification:	2 Accident investig 3 Suicide 6 Could a 4 Homicide determ	not be 28e. Place of Ir	njury - At home, farm, si tc. (Specify)]Yes 2□No	28f. Location (5 City or Tox	Street and Number or vn, State)	Rural Route Number,
	Hospil 24 hour Funer stely fill	edical Co		g Physician: To the bes Examiner: On the basis and manner s	of examination and/or is					
	To the within 2 To the complex	Me	29b. Signature and title of cartifie			29c. Licen			29d. Pate signed (Mo	onth, Day, Year)
	~		Halla V	Messett		000	43375		8/30/06	
,	(10)		30. Name and a dress of erson	who completed cause of	death (Item 23a) (Type	, Print)			6 6	
Karen Merritt M.D. 3160 Gracefield Rd. R1-536 Silver Spring Md. 20904 State 31. Date filed (Month, Day, Year) 22. Registrar's Signature										
		State 31. Date filed (Month, Day, Year) AUG 3 0 2006								

Drien routed has	
Baltimore, Maryland 21215-0036	
permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland	
Department of neeting and Medial Pytjene. Important if item 23 a or 28a-1 ehow and into or other factoring is not being and into or other factoring in a second in the sec	

			1 - For State Registrar	State of Maryland	•	tificate of L			g. No. 2 0 0 1	5 29162
H	Physicia		Decedent's Name (First, Middle, Last) MARTHA	L.	SMITH	I		August	Day Yea	
	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Death	no-jusi	4c. County of De	
	Funeral Director		DOCTOR'S HOSPITA 5. Social Security Number 249-44-8872 6. Sex		st birthday) Yrs.	LANHAM If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, JULY 20	9. E	Sirthplace (State or Foreign Country) UTH CAROLINA
500	*		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
M	flexia	tor	MD PRINCE GE	EORGE'S LA	NDOVEF	2				1 X Yes 2 □ No
ith the	or 28s	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?
d d	234	ral	6902 KENT TOWN DR		10.11	20785	0-1-1-0-10-	-4 V N-	U.S.A.	merican Indian,
III Z I Z I Z I Z I Z I Z I Z I Z I Z I	perior is ago, feath and Mental Mighes. Internations are seen minimum or any man began the feath and Mental Mighes. Internation of them 23a or 28a-1 show any injury or other traumatic event, the Madical Examiner court be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ₹ No If Yes, Give Year or Dates:		Yas Decedent of Hi Yes, specify Cuba ☐ Yes 2 X No	spanic Origin? (Spe n, Mexican, Puerto Specify:	Rican, etc.)	Black, W	
ל ה ה	natur	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	lent's Usual Occupa	furing most of working	ng	16b. Kind of Busine	ss/Industry
within	then the Me	duuc	Elementary/Secondary (0-12)	College (1-4or 5+)	iire. L	NURSE	,		RED CROS	S
7 5	other other	BeC	17. Father's Name (First, Middle, Last)	1			18. Mother's Name	(First, Middle, A	faiden Sumame)	
al y la l	Menta arkad atic e	To	HANK BROWN				CHARLOT			
_ <	h and 7 ie m		19a. Informant's Name/Relationship (Ty)						City or Town, State	
U -	Heelth tem 27 other tr		CHARLOTTE M. GANS 20a. Method of Disposition	20b. Pla	ace of Dispo:	KENT TOWN sition (Name of natory or other place			PIART LAND 20c. Location - City	20785 or Town, State
	nent of h		1 🖾 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	amoval from State		CEMETERY	8/30/	2006	SUITLAND,	MARYLAND
	Dapartr Importa eny inju		21. Signature of Funeral Service License	10		. Name and Addres	_			ERAL HOME
	10200		23a. Part1. Enter the disease, or complishock, or heart failure. List only on	cations that caused the death					ER, MARYLA	Approximate
	hysician /Medical		shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Metastat Due to (or as a consequence of the conseq	tic A	denocas	cinom	a of C	olon	Interval Between Onset and Death 2 YYS
	xaminer		Conventially list appolitions	Pulmonary	1 M.	etaston	ois of	colon (concer	6 months
7	s = s	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consect	ence of):					
VISION OF VICE INCCOLUS, F.O. DOA 60/00,	g physicien and as the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consequ	ence of):					
2 4	nysicie ne buri	edical	L _a							
A COUNTY	ding ph		IF FEMALE:	2- 11						
אסם פוניים	ideath. tor: After this certificate has been signed by the ettendin the funeral director, page 2 should be detached for use.	Physician/N	in the past 12 months?	3c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
; i	by the	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
<u>,</u>	igned be de	þ	Part II. Other significant conditions con Malnutzition	tributing to death but not resu	lting in the ur	nderlying cause give	en in Part I.			to the cause of death? Probably 4 □Unknown
cords,	been s	Completed	7 (00170) ((110))					1 Ye		
ב ב	e hes	Jumo						24a. Was ar autops perform	y prior ned? death	autopsy findings available to completion of cause of
2	rtificat	Be Co	25. Was case referred to medical				26. Place of Death		X∑ No 1 □ Y	es 2⊠ No
> 10	this ce	ပ္	TO THE ZE INC		R/Outpatien		4 Nursing Ho		nce 6 Other (S	pecify)
	After funera	tlon;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	yat ⟨? Yes 2 □No	28d. Describe ho	w injury occurred	
	octor: by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of Injury - At hor building, etc. (Specify,				28f. Location (St. City or Town		Rural Route Number,
5 }	rai Dir									
3	within 24 hours after death. To the Funeral Director; A completely filled in by the ft	Medical	29a. Certifier 1 Certifying Physical Check only 2 Medical Examinates	sician: To the best of my know ner: On the basis of examinati and manner stated.	vledge, death ion and/or inv	occurred at the time restigation, in my of	ne, date and place, a pinion, death occurr	and due to the ca ed at the time, da	use(s) and manner ite and place, and c	as stated. lue to the cause(s)
10.0	within To the	Me	20h Signature and title of certifier			29c. License	number	25	9d. Date signed (Mo	onth, Day, Year)
·			30. Name and address of person who co	makimo		1005	0213		8/23/	2006
2	10)		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type,	Print)	PKWY (oreeu6	elt MD	20770

State Registrar 31. Date filed (Month, Day, Year) AUG 2 9 2006



		,	1 - State of Maryland	-	rtment of H			ene 2006	29163
7	1.09	× =	Decedent's Name (First, Middle, Last)				2. Date of Death	1	3. Time of Death
	Physici		JOYCE PANDORA STONER			-	Month August	Day Year	0809 M
	/Medio		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	110701	4c. County of Death	
		200	Prince George's Hospit	al	Che	everla		Prince	George's
	, Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las	st birthday)	il Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Birth	nplace (State or Foreign
	Director		578 70 3898 1□M XX F 54	Yrs.	Months Days	Hours Will.	AUG. 08,	1952 WASI	HINGTON, DC
	p >		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Loca	otion				10d. Inside City Limits
	eho.	'n			ation				1 ☐ Yes XX No
	Ne N	Director	MD PRINCE GEORGES BOW 10e. Street and Number	1E	10f. Zip Code		1.10	Cities of Mines Co	
	death with the Maryland ms 23s or 28e-f ehow r.must be notified at		1708 APPLE BLOSSOM COURT		'	20721	10	g. Citizen of What Co UNITED STA	-
	eath	era	11. Marital Status 12. Was Decedent Ever in U.S.	13 W			acty Yes or No-	14. Race - Amer	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "naturet; or Items 23a or 28e-f show wayl figury or other traumatic event, The Madical Examinat must be notified at ance.	by Funeral	1 Never Married Married 1 Yes, Give 3 Widowed 4 Divorced Year or Dates:		Yes, specify Cubar	spanic Origin? (Spin, Mexican, Puerto Specify:	Rican, etc.)	Black, White	
21215-0036	2 hou				ent's Usual Occupa			6b. Kind of Business/l	ndustry
75	hin 7.	Completed	(Specify only highest grade completed) Elementary/Secondary (0·12) College (1-4or 5+)	(Give ki	and of work done a O NOT use retired,	furing most of work)	ng		
21	giene giene	E O		ADMINI	STRATIVE	ASSISTAN	NT	PRIVATE	
덜	al Hy al Hy d oth	Be (17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, M	laiden Sumame)	
/a	Menti Menti mrked artice	2	FILMORE REDMAN			NETTIE N	1AE OWENS	5	
Maryland	and and le mu		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	g Address (Street a	and Number or Rura	al Route Number,	City or Town, State, Z	ip Code)
2	and ealth m 27				APPLE BLO			MD 20721	
0	ges 1 t of H if Ite or ot		XXBurial 2 ☐ Cremation 3 ☐ Removal from State	netery, crema	ition (Name of atory or other place	9)		toc. Location - City or 1	Iown, State
Ë	tent:					L CEM. 8		SUITLANI	*
Baltimore,	Depar Depar Impor eny In		21. Signature of Euneral Service Licensee			S FUNERAI LAND ROAI		F MARYLAND, LAND, MD 20	
•.			23a. Part Tenter the disease, or complications that caused the death. shock, or heart lailure. List only one cause on each line.	Do not enter	r the mode of dying	g, such as cardiac o			Approximate Interval Between
*:	Physician		Immediate Cause (Final disease or condition resulting in death) a. Arteriosclumate Due to (or as a conseque	erotic	- Hypey	tensove	Heart	Disease	Onset and Death
46	/Medical Examiner		resulting in death) Due to (or as a conseque	ince of):					
	CXAIIIIICI	L	Sequentially list conditions, b.						
	pe all	Examine	if any, leading to immediate Due to (or as a conseque cause. Enter Underlying Cause (Disease or injury	nce oi):					
	certificate be executed nding physician and use as the burial-transit	xan	that initiated events resulting in death) Last	ince of):					
8760,	be e sician buria	dical E						4	
687		융	d.						
Вох	eath certif attending for use as	N/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnand					23d. Date of deli	very
ă	death e atten	by Physician/Me	in the past 12 months? 1 Vas 3 No 4 Pregnant at time of dea		Ectopic pregnancy Other (specify)			Month	Day Year
0	the ache	hys	9 Unknown						
٥,	rw requires that the s been signed by th should be detache	y P	Part II. Other significant conditions contributing to death but not result	ing in the und	derlying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Ë	en sig						1 Tes	s 2 No 3 Pro	bably 4 Unknown
of Vital Records	2 sb	Completed					24a. Was an autopsy	24b. Were au	topsy findings available ompletion of cause of
<u>ac</u>	The ate h page)or					perform	ed? death?	2 No
ita	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner:			26. Place of Death	(Check only one)	
<u></u>	8 v 5	၉	1'☐ Yes 2☐ No Hospital: 1 ☐ Inpatient 2 ☐ El	R/Outpatient		4 Nuising no	me 5 Resider	nce 6 Other (Spec	uty)
C C	ding Ph th. After the funeral	ü	27. Manner of Death 28a. Date of Injury 1 ☐ Natural 5 ☐ Pending (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe how	w injury occurred	
Sio	Attanding r death. actor: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be			Yes 2 □No			
Division	f or Attano after death Director:	Certification;	4 Homicide determined 28e. Place of Injury - At hom building, etc. (Specify)	e, tarm, stree	et, factory, office		City or Town,	eet and Number or Ru. State)	rai Houle Number,
	Hospitel 24 hours a Funeral I		29a. Certifier 1□ Certifying Physician: To the best of my knowl	ledge death	occurred at the tim	e date and place	and due to the car	use(s) and manner as	stated
		edical	(Check only 2. Medical Examiner: On the basis of examination one) and manner stated.	n and/or inve	estigation, in my op	pinion, death occurr	ed at the time, da	te and place, and due	to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier		29c. License	number	29	d. Date signed (Month	. Day, Year)
			I Salvador Sheete Do		No.	05192	7 /	August 2	7 2006
R	(5)		30. Name and address of person who completed cause of death (Item 2	23a) (Type, P	Print)			0	7, 2006
1	Sta	to	31. Date filed (Month, Day, Year) AUG 2 9 2006 AUG 2 9 2006	Hos	situl	Drive	معلى	y, Ma	y/and
	Registi		AUG 2 9 2006	Apart	W				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Physician 2:50 AM MARTHA CONSTANCE SMITH 2006 August 24 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Prince George's Hospital Center Cheverly | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 4, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex , 1917 Washington, DC **Funeral** Months 1 ☐ M 2 💢 F 89 578-14-0245 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 1X Yes 2 □ No Cheverly Directo Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2900 Mercy Lane 20785 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Marned tf Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Josephine Brooks George Washington Smith ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4639 6th Street, SE Washington, DC Reginald D. Tarver (Grandson) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery crematory or other place 1 X Burial 2 Cremation 3 Removal from State 8/31/06 Lincoln Memorial Cem. Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Jordan Funeral Service, Inc. 21. Signature of Funeral Service Licensee 4001 Benning Road, NE Washington, DC Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Cardiac Arrest /Medical Due to (or as a consequence of) **Examiner** Congestive Heart Failure Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). by Physician/Medicai Examiner To the Hospital or Attending Physicism: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the humat reason. Atrial Fibrillation Due to (or as a consequence of): Box 68760. Hypertensive Cardiovascular Disease IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2X No 1 Tyes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 28a. Date of fnjury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Hispital Drive Cheverly, Ophnell Cumberbatch, MD 20785 31. Date filed (Month, Day, Year) State Registrar AUG 2 8 2005

		1	For State	State of Mary	land / Depa	artment of H	ealth and		ne 2006	29165
*	Physicia	20	Registrar 1. Decedent's Name (First, Middle, Last,)	007	inoaic or i	Joann	2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin	al er	Lavern Smith 4a. Facility Name (If not institution, give Prince Georges		Center	4b. City, Town, or Chever		August	19 2006 4c. County of Death Prince	
227	Funeral Director		5. Social Security Number 6. Se 579-64-5977	7. Age (In	yrs. last birthday) 7rs.	If Under 1 Year Months Days				nplace (State or Foreign ugtry) Shingten
	the Maryland 28a-f show	Director	Usual Residence of Decedent		c. City, Town or Lo			100	. Citizen of What Co	10d. Inside City Limits 1 Yes 2 □ No
98	s 1 and 2 should be fited within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other treumatic event, i'm Madical Examinar must be neiting a	rai	9104 Lake Largo 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 MDivorced	Drive 12. Was Decedent Ever Armed Forces? 1 \(\text{Yes} \) 2 \(\text{M} \) No If Yes, Give Year or Dates:		20774 Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S in, Mexican, Puer Specify:	Un	ited Sta 14. Race - Ame Black, White Specify: B1	ntes ncan Indian, e, etc.
21215-0036	i within 72 hou jene. r than "natura the Madical E	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual Occupi kind of work done of DO NOT use retired ning Spe	during most of wo f)		b. Kind of Business/ rug Enfo dministr	
-	2 should be filed and Mental Hygi le marked other eumatic event,	To Be C	17. Father's Name (First, Middle, Last) Rufus Jones					me (First, Middle, Mai y McHenry		
	1 and 2 sho Health and I Iom 27 Io me		19a. Informant's Name/Relationship (T) Kimber Smith/D	aughter	The second second	Scott A	dam Cou	ural Route Number, C	el, Md.	20708
Baltimore,	t. Page rtment o rtant: If njury or		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Egneral Service Licens	Removal from State	Nation:	natory or other place al Harmo	$\frac{1}{2}$	ust 25 6 La	ndover,	
Ba	Depa Impo eny it		23a. Part 1. Enter the disease, pr comp shock, or heart failure. List only o	Bell &	4	804 Geor	gia Av	e. NW Wa	shington	20011 a, DC Approximate Interval Between
8760,	Physician /Medical Examiner	al Examiner	Immediate Cause (Final disease or condition resulting in death)	a. Esophage Due to (or as a co	eal Candonsequence of):					Onset and Death 6 Months
.O. Box 687	The law requires that the death certificate be executed to as been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ¼No 9 □ Unknown	d	Fetal death 3	□Ectopic pregnancy	,		23d. Date of del Month	ivery Day Year
<u>α</u>	quires that the signed by ald be detacted	ρ	Part II. Dther significant conditions co	ntnbuting to death but no	of resulting in the u	nderlying cause giv	en in Part I.			othe cause of death?
Vital Records,		Completed	Tabacco Depend	ence				24a. Was an autopsy performe	d? prior to death?	itopsy findings available completion of cause of 2 X No
Vita	Physician: Th this certificete ral director, pag	То Ве	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient	2⊠ ER/Outpatie	nt 3□ DOA Oth	00	ath (Check only one) Home 5 Residence	e 6 □Other (Spec	city)
Division of	ding h. After fune	Certification: T	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Ye 28e. Place of Injury- building, etc. (S	At home, farm, st	M 1 □		28d. Describe how	injury occurred et and Number or Ru	
	Hospite 24 hours Funeral tely filled	edicai Ce	29a. Certifier Certifying Phyone) Certifying Phyone	vsicien: To the best of m iner: On the basis of exa and manner stated	amination and/or in	h occurred at the tire evestigation, in my o	πe, date and plac pinion, death occ	e, and due to the caus urred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of earther	MIV	En S	29c. Licens	9 number	290	. Date signed (<i>Mont.</i>	h, Day, Year)
2	(1)		30. Name and address of pe on who o				e ST. I	Laurel, A	1d - 2070	7
€.	Sta Regist	ate	31. Date filed (Month, Day, Year) AUG 2 8 2006	2. Registrar's	Signature					.500

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2006 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Rosie Smith Lee August 23 2006 2:17A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges Hospital Cheverly P.G. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

84 Yrs. Months Days Hours Min. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 😾 F 84 238-78-4327 Director 11-3-21 N.C Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. Count ns 23a or 28a-f show XXYes 2 No Completed by Funeral Director MD. P.G. Capitol Hgts. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 906 BalsamTree Place 20743 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes **2020**No If Yes, Give Year or Dates: 1 Never Married 2 Married ō Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black 3€ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Housewife Hame 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fill Department of Health and Mental Hy Important: If item 27 Is marked oth any injury or othar traumatic event Be 18. Mother's Name (First, Middle, Maiden Sumame) Roy Robeson Martha Boone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Roy S. Smith/Son 906 BalsamTree Pl. Capitol Hgts. Md. 20743 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 8/30/06 Bladen City, N.C. Spring Branch Cem 21. Signature of Funeral Service Licensee 22. Name and Address of Facility The House of Williams Fun. Svc. 814 Upshur Street, N.W. and E. Willerin 23a. Vart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hypertensive Cardiovascular Disease /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of by Physician/Medical Examiner and I-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of): sician ar P.O. Box 68760. phys. nding pl IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Decompensated Congestive Heart Failure 1 Yes 2 No 3 Probebly WUnknown Completed Coronary Artery Disease / Pulmonary Edema 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page Diabetes Mellitus / HTN 1X Yes 2 □ No X Yes Division of Vital 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 XInpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification; 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attanding 1 Natural 5 Pending Injury after death. I Director; Afi d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide vithin 24 hours a o the Funaral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cerand 30. Name and address of person who ampleted cause of death (Item 23a) Tyre, Print) Margaret Akpan, M.D. 3001 Hospital Dr. Cheverly, Md. 20785 31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 29 2006 Registrar

			1 - For Stata Registrar	State of Marylar		rtment of I			giene Reg. No. 200	6 29167
	Physici /Medic		1. Decedent's Name (First, Middle, Last, Anthony C	Subako				2. Date of De Month	ath Day Yea 27-200	
	Examin Funeral Director		169-62-4483	Adventist	HOSPi last birthday) Yrs.	4b. City, Town, of the Lift Urider 1 Year Months Days	POCKVIC If Under 24 Hrs Hours Min	LLE 8. Date of Birt	4c. County of De Monto. Monto. 19. B. B. B. B. B. B. B. B. B. B. B. B. B.	PA.
	ehow	ľ	Usual Residence of Decedent 10a. State 10b. County		ty, Town or Loc					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	or 28a-f	Olrecto	MD • MONTGOME I 10e. Street and Number	RY	G.	AITHERSE 10f. Zip Code	BURG		10g. Citizen of What (
336	n 72 hours after death with the Maryland "netural", or flems 23a or 28a-f ehow calcul Exemination must be notified at	by Funeral Director	18622 GROSBEAN 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ⑦ Divorced	TERR。 12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:			1879 Hispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	Specify:	nerican Indian,
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-	and 2 leelth a m 27 le			KA/MOTHER	3032	FINSEL	and Number or R	EY, MD.		
Baltimore,	mit. Pages 1 partment of H portent: If its y injury or oti		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State C1	HAMBERS	atory or other pla	RY 8-28	Date -2006	20c. Location - City of RIVERDALE	. MD.
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	Physician /Medical Examiner		23a. Part1. Enter the disease, or compishook, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	ications that caused the deal ne cause on each line. Due to (or as a consect)	5	r the mode of dyi	ng, such as cardia	c or respiratory ai	rrest,	Approximate Interval Between Onset and Peath
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of Vit	8 % FD	To Be	25. Was case referred to medical examiner? 1 Yes 2 0	Hospital:	ER/Outpatient	3□ DOA Ott	or	ath <i>(Check only c</i> Home 5□ Resid	nne) dence 6 □Other (Sp	pecify)
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Divi	후 를 들 드	Certifle	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, larm, stre	et, factory, office		28f. Location (S City or Tox	Street and Number or vn, State)	Route Number,
	he Hospital of 24 hours at he Funeral Dietely filled i	edical	29a. Certifier Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death ation and/or inve	occurred at the tilestigation, in my o	me, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	To the within 2 To the Complet	M	29b. Signature and title of certifler	The ME	>	29c. Licens			29d. Date signed (Mg	nth, Day, Year)
	5		30. Name and address o person o co Brandon Falk	ompleted cause of death (Iter	n 23a) (Type, F	Center	Drive	Rock	sille, MD	20850
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 9 20	32 Hegistrar's Signi	de Go	refer				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Denartment of Health and Mental Hydiene O. O. C.

			For State Registrar		aryland / L	Jepa Cer	rtment of Healt tificate of Dea	th	Re	ene2 0 0 6	
	Physici /Medi		1. Decedent's Name (First, Middle, Las Debra An		ott	Sac	ly		2. Date of Death Month EPTEMBEI	Pay Year 2006	3. Time of Death 1:42 P M
	Examir	5 7	4a. Facility Name (If not institution, give CIVISTA MEDICAL)		4b. City, Town, or Locat LAPLATA			4c. County of Dea	
3	Funeral Director		219-74-0668	9x 7. Ag □ M 2 ️ F	ge (In yrs. last bir 49	rthday) Yrs.	If Under 1 Year If Un Months Days Hou	nder 24 Hrs. g	July 14	9. Bi 1957 Wash	thplace (State or Foreign ountry) nington, DC
	with the Maryland a or 28s-f show the notified at	or	Usual Residence of Decedent 10a. State 10b. County Maryland Charl	0.6	10c. City, Tow						10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	r 288-	Director	10e. Street and Number	-8	Indgi	ICSV.	10f. Zip Code		10	g. Citizen of Whal C	ounlry?
	23a o 23a o 23 bu	aiD	6170 Trotters G1	en Drive			20637			USA	
21215-0036	72 hours after death wii natural', or items 23a d dical Examinar must o	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces: 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	? No		/as Decedent of Hispanic Yes, specify Cuban, Med ☐ Yes 2₺ No Spe	c Origin? (Spec xican, Puerto R ecify:	ify Yes or No- ican, etc.)	14. Race - Am Black, Whi	
5-0	n 72 ho natur	letec	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a	. Decede	ent's Usual Occupation and of work done during O NOT use retired)	most of working	7	6b. Kind of Business	/Industry
212	filed within 72 ho Hygiene. Ither than "natur int, me Medical	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		es Represen			Advertis	sing
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Balti	permit. Departn Imports sny inju		21. Signature of Funeral Service Licen	T pts	 M00641	Br.	Name and Address of Finsfield-Ec.	hols Fu Charlo	neral Ho tte Hal	ne MD ^P 206	22
	Physician		23a. Part 1. Enter the disease, or companies, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	1	d the death. Do	not ente	/		respiratory arres	st,	Approximate Interval Between Onset and Death
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of Vital Records,		Completed							24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of s 2 No
Vita	Physician: Th r this bertificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:					Check only one		
to	Phys r this ral di); To	1 Yes 2 No 27. Manger of Death	28a. Date of Inju (Month, Da	ury 28b.	Time of	3 DOA 28c. Injury at Work?			ce 6 Other (Speringury occurred	ecify)
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Division	2 5 5 5	Certification;	3 Suicide 6 Could not be 4 Homicide determined	286. Place of in	jury - At home, fa tc. (Specify)	arm, stre	et, factory, office	28	8f. Location (Stre City or Town,		lural Route Number,
	To the Hospital of within 24 hours at To the Funaral Completely filled it	edical	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best niner: On the basis of and manner st	of examination ar	e, death nd/or inv	occurred at the time, dat estigation, in my opinion,	te and place, ar death occurred	nd due to the cau d at the time, dat	ise(s) and manner a e and place, and du	s stated. e to the cause(s)
	To the comp	Σ	29b. Signature and title of pertifier				29c. License numl	ber		d. Date signed (Mon	
					- u	m	D-005	3219	0	7/2/20	06
			30. Name and address of person who ZAFAR A. ANSARI.		death (Item 23a) OST OFF]		•	F MD	20602		
	Sta Regist		31. Date filed (Month, Day, Year) SEP 0 6 2006	32. Regist	rar's Signature		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	- 1111	<u> </u>		

Arthur Louis Siebert

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Ithur Louis Sie	1	- For State Climaryiand / Department of Fleath a	and Mentarri		No. 211	6 2916						
Physici	an/	Decedent's Name (First, Middle,Last)		2. Date of Death Month September	Day Year	3. Time of Death 0807 hrs						
fledical Exami ∕∵		Arthur Louis Siebert 4a. Facility Name (if not institution, give street and number) 4b. City, Town	, or Location of Death	September	5, 2006 4c. County of Death							
		21841 Three Notch Road Lexington			St. Mary's							
Funeral Director		219-56-0759 1X M 2 F 55 Yrs.	Year If Under 24Hrs Days Hours Min.	8. Date of Birth	Foreig	hplace (State or n untry) Maryland						
any	_ <u> </u>	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits						
daryland 28a-f show any 1 at once.	ō	Maryland Saint Marys Lexington Parl	k			1 Yes 2 No						
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 10f. Zip Cod		100	g. Citizen of What Cour	ntry?						
		48705 Far Cry Road 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of	20653 f Hispanic Origin? (Sp	pecify Yes or No-	USA 14. Race - Ameri	can Indian, Black,						
death w	nue	1 Never Married 2 Married Armed Forces? If Yes, specify Cu	uban, Mexican, Puerto	Rican, etc.)	White, etc.							
s after raf", o	by F	3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 X		work done	Specify: Wh	ite						
2 hour "natu	ğ	Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)			TOD. KING OF BUSINESSY	, idustry						
5-0036 led within 72 hours afte Hygiene other than "natural", the Medical Examiner	Completed	12 0 Mechanic			Automoti	ve						
ore, MD 21215-0036 es 1 and 2 should be filed within 72 hours a of Health and Mental Hygiene If iten 27 is marked other than "natura ther traumatic event, the Medical Examir	Be Co	17. Father's Name (First, Middle, Last)	18.Mother's Name	y E.O'E	,							
2121 2121 Judy be fi Mental is marked		Walter Carl Siebert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (S		-	, Zip Code)							
M 2 alth: alth: an 2 au m		Mary Elizabeth Merritt/ Daughter P.O. Box 4 20a Method of Disposition 20b. Place of Disposition (Name o	ryland 206	80 20c. Location - City or	Town State							
Baltimore, permit Pages I as Department of Hee Important: If ite		1 Burial 2 X Cremation 3 Removal from State crematory or other place)		eptember	200. Education - Oity of	Town, olde						
Baltimo permit Page Department o Important: injury or oth	1	4 Donation 5 Other Specify: Metropolitan Crema 21 Signature of Funeral Service Licensee 22 Name and Add	2006	Alexandria,								
Balti permit Departu Import	r yl			P.A. Maryland 2	20650 Approximate Interval							
Physician /Medical		23a. Part t. Enter the discase, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
xaminer		Immediate Cause (Final disease or condition resulting in death) By Pertensive atherosclerotic carried by Due to (or as a consequence of):	ardiovascular	disease		Death						
		Sequentially list conditions, b.										
	nine	if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated										
760, irate be executed g physician and the burial - transit	I Examiner	events resulting in death) Last Due to (or as a consequence of): d.										
60, ate be exe hysician a	/Medical	x unpended AMENDED #23a,PII,27,perME,g860, 10/3	30/06 TT									
OX 68760, eath certificate be ex attending physiciar for use as the burial	M/ut	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 Ectopic pregna	ancy	23d. Date of deliver Month	y Day Year						
Box 687 E death certific the attending F ed for use as th	Physician/	4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown										
that the de ned by the detached is	H _C	Part II. Other significant conditions contributing to death but not resulting in the underlying cau	use given in Part I.	23e. Did to	pacco use contribute to	the cause of death?						
Division of Vital Records, P.O. ra for Artending Physician: The law requires that that that that that that that tha	Completed by	Chronic obstructive pulmonary disease			2 No 3 Pro							
ords, aw requir as been a	plet			24a. Was a autops perfor	sy prior to	utopsy findings available completion of cause of						
tal Rec tian: The li certificate h		20.	Place of Death (Check	1 ✓ Yes 2		es 2 No						
Vital F ysician: his certifi director,) Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	TOthor:		Residence 6 🗸 Othe	r: Scene						
ing Phy After th	n: To	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c.	. Injury at Work?	28d. Describe h	ow injury occurred							
Sion Attendi death cctor:	catio	Accident Investigation 28e. Place of Injury - At home, farm, street, factory, off	Yes 2 No	28f Location (S	treet and Number or Pi	ural Route Number, City						
Division spital or Attendi hours after death neral Director:	Certification:	3 Suicide 6 Could not be determined (Specify)	nce building, etc.	or Town, St		dial Route Number, Orty						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my op	ne, date and place, and pinion, death occurred	d due to the cause at the time, date a	e(s) and manner as sta and place, and due to the	rted. ne cause(s)						
To t com	Medical	and manner stated	icense number		29d. Date signed (Mo							
		John Cahilla A.	D.C.M.E.		September 6, 20	006						
		30. Name and address of person who completed cause of death (Item 23a) Zabjullah Ali, M.D. Assistant Medical Examiner 111 Penn Street,	Baltimore MD 21	1201								
	State	22 Parintrada Cianatura										
Regi		0 = 0 0 0000 10 11										

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) SEFTEMBER Day 2006 Physician Charles Randolf Specher /Medical 4c. County of Death
Baltimore 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical Center Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1**⊠**M 2□ F Yrs. 82 219-12-0205 Director January 1,1924 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County r than "netural", or Iteme 23s or 28s-f ehow the Medical Examiner must be notified at 1 Kres 2 No Directo Maryland Washington Smithsburg 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5 East Water St. P.O. Box 34 21783 U.S.A. death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 X Yes 2 □ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: 2 3 ☐ Widowed 4 ☐ Divorced 43 - 45Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education permit. Pages 1 end 2 should be filed within 7. Depertment of Health and Mental Hygiene. Important: If item 27 ie marked other than "ne eny injury or other traumatic event, the Media 2008. (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Truck Driver Cement / Concrete 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lula Slick Charles Sprecher ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10632 Peach Tree Ln. Williamsport, Maryland 21795 Barbara Russell (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition September 11 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg Cemetery 4 □ Donation 5 □ Other (Specify) 2006 Smithsburg, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee J.L. Davis Funeral Home MOI414 12525 Bradbury Ave. Smithsburg, Maryland 21783 20a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE MYOCARDIAL INFARCTION **Physician** /Medical SEVERE CORONARY ARTERY DISEASE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.0. 9 Linknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Division of Vital Records. CONGESTIVE HEART FAILURE 2 No 3 Probably 4 □Unknown 1 Tes Be Completed ACUTE RENAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Tyes VENTILATORY FAILURE 1 ☐ Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To After the 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 ANatural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 150 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D 37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOON P. LIM. M. D. . 7601 OSLER DRIVE TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State SFP 1 3 2006 Registra

DHMH 17 Rev 1/2001

ORIGINAL

06-06395 Ernest Tillely

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

nest Tillely		For State Control of Proceedings of Procedure And Procedur
Physician		l. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year 1614 hrs
edical Examine	er.	Ernest Lee lillery August 26, 2006
	4	Fort Washington Medical Center Fort Washington Medical Center Fort Washington
Funeral	5	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign
Director		577-98-6669 _{1X M 2} F 41 Yrs. Jan. 30,1965 Country VA
any	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No
faryland 28a-f show 1 at once,	<u>ē</u>	Maryland Prince George Fort Washington
or 28a-	Director	10e. Street and Number 9602 Windermere Court 20744 United States
with the ns 23a be noti		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
MD 21215-0036 ad 2 should be filed within 72 hours after death with the Maryland lith and Mental Hygiene. m 27 is marked other than "natural", or items 23a or 28a-f she anumatic event, the Medical Examiner must be notified at once	리	1 Never Married 2 Married 1 Yes 2 X No specify: Never Married 2 Married 1 Yes 2 X No specify: Specify: Black
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Itant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examines.	- P	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
136 thin 72 ho e. than "na edical Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Restaurant
J withii giene.	탉	12th Walter 18. Mother's Name (First, Middle, Last) 17. Father's Name (First, Middle, Last)
21215-0036 Juld be filed within 7 Mental Hygiene. neverked other than neverk, the Medica	8	Ernest Council Faye Osby 19a Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
D 21 should and Me 7 is nra	유	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2ip Code) 9602 Windermere Ct. Fort Washington, Md. 20744
e, MD and 2 sho Health and item 27 is	1	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State
MOF	1	Resurrection Cem. 09/02/2006 Clinton, Maryland
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Media	1	22. Name and Address of Facility Pope Funeral Homes, P.A. 5588 Mariboro Pike, Forestville, Md. 20747
Physician	\dashv	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset an
xaminer	1	Immediate Cause (Final disease a, Exsanguination
		or condition resulting in death) Due to (or as a consequence of): b. Erosion of Dialysis Arteriovenous Fistula complicated by methadone intoxication
	je l	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause
.2	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
Records, P.O. Box 68760, The law requires that the death certificate be executed toate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	ਛ	d. UNPENDED X AMENDED item#23a 27 28a-f perME 0860 10/11/06 TT// item#1.perME
60, ate be ex hysiciar te burial	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery
6876 ertifical ding ph	ian/N	less that the development is the Line Year
Box 687 e death certific the attending p	Physician/	1 Yes 2 No 9 Unknown g Unknown g Unknown
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Cord law rec has bee	Completed	autopsy performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
Recipient The	Co	1.25 Was case referred to medical
Vita ysician this cer direct	o Be	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 VER/Outpatient 3 DOA Other 1 Nursing Home 5 Residence 6 Other:
n of ling Ph After funeral	on: T	127 Manner of Fleath 120d, Date of Hilling 1200, Title of Hilling 1
Sion Attendi r death. ector: by the f	catic	Pending Investigation Fnd 8/26/2006 Fnd 3:00 pm Tes 2X Fistula while intoxicated Fnd 8/26/2006 Fnd 3:00 pm Fnd 8/26/2006 Fnd 8/26/20
Divi	Certification:	3 Suicide 6 Could not be determined (Specify) Residence or Town, State) 9602 Windermere Turn Fort Washington, Windermere Turn
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwitin 24 hours after death. To the Finteral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial.	ical C	
To the with To the Company	Medical	and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)
		O.C.M.E. August 27, 2006
CN (3)		30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
S	tate	e 31. Date filed (Month, Day, Year): 32 Registrar's Signature
Regis	stra	
DHMH 17 Rev 1/	2001	ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

			1 - For State Registrar	State of Maryland /		nt of Health ar te of Death	nd Mental Hy	giene,	2006	29172			
	Physici	an	1. Decedent's Name (First, Middle, Last)		00,1,1100		2. Date of D	eath Day	Year	3. Time of Death			
	/Medic	al	4a. Facility Name (If not institution, give	stelle Tancil	4b. City	, Town, or Location of	August Death		2006 County of Death	6:15PM			
6			Summerville Ass	isted Living		owie	LHrs 8 Date of B			eorges			
""	Funeral Director		5. Social Security Number 6. Sec 578 - 54 - 2009	M 2XF 90	Yrs. Months		Min. (Month, D	ay, Year) 4 191	. Coun	Rington D.S.			
	yland		Usual Residence of Decedent 10a. State 10b. County	_	wn or Location				1	Od. Inside City Limits			
	the Mar 28a-1 et	Director	Maryland Prince G	teorges Bou	0ie	p Code		10a Citiz	en of What Cour	1 Yes 2 No			
	23a or		12213 Rolling +	till Lane		20715			1. S. A				
920	i 72 hours after death with the Maryland "natural", or Iteme 23a or 28a-1 ehow suical Expraner, was be natified at	by Funeral	11. Marital Status Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 No If Yes, Give Year or Dates:	13. Was Dece If Yes, spo	dent of Hispanic Origin acify Cuban, Mexican, I 2 No Specify:	n? (Specify Yes or N Puerto Rican, etc.)	2 (Specify Yes or No- uerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: Black					
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Maryland	ould be filed Mental Hygid arked other atic event,	To Be C	17. Father's Name (First, Middle, Last) Un Knowr)			s Name (First, Middle Un Knou		Sumame)				
	s 1 and 2 should I Health and Men Item 27 is marke other traumatic		19a. Informant's Name/Relationship (Ty Robert B. Hunter	Sc./Guardian 1	s (Street and Number				/ -				
Baltimore,	0 0 = =		20a. Method of Disposition 1 Burial 2 Coremation 3 F 4 Donation 5 Other (Specify)	20b. Place cemet	e Crematory	Date Aug. 33,200	Bel	ts ville	Maryland				
Balti	permit. Pag Department Importent: any injury o		21. Signatur of Funeral Service Licens	Slorum	22. Name a	and Address of Fability Allenteun	Strickla Road Ca	nd Fi	ineral So orings, 1	MD 20748			
i de			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.		^	ardiac or respiratory	arrest,		Approximate Interval Between Onset and Death			
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence		Disease				10 years			
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	ate be executed obysician and the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	a of):								
8760,	ate be ex hysician the buria	Ical E		d	J 317.								
9	eath certifica attending phy I for use as th	ed	IF FEMALE:	23c. If yes, outcome of pregnancy				2	2d Date of delive				
P.O. Box	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Fetal dear 4 ☐ Pregnant at time of death 9 ☐ Unknown	th 3 □Ectopic p 5 □ Other (s				3d. Date of delive Month	Day Year			
	quires that an signed b uld be dett	þ	Part II. Other significant conditions con	ntributing to death but not resulting	in the underlying	cause given in Part I.		Δ.	,	ne cause of death?			
Records,	The law requ zate has been page 2 shoul	Completed					24a. Wa auto per 1 [] Yes	s an opsy formed? 2)X No	prior to con death?	psy findings available mpletion of cause of			
Vital	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		! Othors	of Death Check only	оле)	W.	0.01/10			
of	ding Phys h. After this funeral dir	tlon: To	1 Yes 2 No 27. Manner of Death Natural 5 Pending 2 Accident investigation	1 [] Inpatient 2 [] ER/C		OA 4 Nurs 28c. Injury at Work? 1 Yes 2 No	28d. Describe		Other (Specific occurred	NASSISTED LIVERS			
Division	i or Attendi after death. Director: A d in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, facto	ry, office		(Street and own, State)	Number or Rura	l Route Number,			
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical C	29a. Certifier Check only one) Certifying Phy 2 Madical Exami	sician: To the best of my knowled ner: On the basis of examination a and manner stated.	ge, death occurre and/or investigatio	d at the time, date and n, in my opinion, death	place, and due to the occurred at the time	e cause(s) e, date and	and manner as s place, and due to	lated. the cause(s)			
	vithir vithir comp	Me	29b. Signature and title of certifier	· / O	- 4	D 50343		A	signed (Month.	2006			
<u>,</u>	(4)		30. Name and address of person who co	mpleted cause of death (Item 23a) (Type, Print)	7 703 73		1149	1st 30,	2000			
1	10		Kelvin Hao MP 149	199 Health C	enter 1	rive #20	1 Boure	Many	land 2	20716			
	Sta Regist		31. Date filed (Month, Day, Year) AUG 3 0 200 5	ompleted cause of death (Item 23a 299 Health (22. Registrar's Signature	porte								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No.2 1 Decedent's Name /First Middle Last) 2 Date of Death **Physician** 222006 /Medical 4b. City, Toy County of Death Examiner **Funeral** Days 2 🗆 F Director 10d. Inside City Limits 10c. City, Town or Location or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Completed by Funeral Director 10g, Citizen of What Country? Items 23a 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 2 Married permit. Pages 1 and 2 should be filed within 72 hours after Depertment of Heelth and Mental Hygiene. Important: if item 27 is marked other than "naturel", or leny injury or other traumatic event, the Medical Examinance. 1 Never Married 2 No Baltimore, Maryland 21215-0036 Yes, Give 3 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use petiged) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Governmen (First, Middle, Last) irst, Middle, Maiden Be nomas ျှ Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or 20b. Place of Disposition (Name of cemetery, crematory or other) Cremation 3 R 3 Removal from State 21. Signature of Funeral 23a. Part1. Enter the disease, or complications that caused it shock, or heart fature. List only one cause on each line or complications that caused the death. the mode of dving, such as cardiac or respiratory Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 6 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ours eftar death.

Nerel Director: Attar this centificete has been signed by the attending physicien and filled in by the funeral director, page 2 should be deteched for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 JUaknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tyes 2 J.No 2 ER/Outpatient 3□ DOA 27. Manner of Death 28c. Injury at Work? Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours e To the Funerel C 1 certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier 29b. Signature and title of 29c. License number 06 leted cause of death (Item 23a) (Type, Print) 20902 801 32. Registrar's Signature State 2006 Registrar

			For State Ragistrar		5	State of I	Marylan		artmer <i>rtifica</i> i				Mental H	ygien Reg. Na	/	6	291	74
	انداك		Decedent's Nam	e (First, Middle	e, Last)								2. Date of D				Time of De	eath
	Physici /Medic		Frances	Hill T	rini	te							August				9:07a	ım M
	Examin		4a. Facility Name (I	If not institution	n, give str	eet and numb	er)		4b. City	Town, or	Location	of Death			c. County of De			
			Suburbar						-	resda r1 Year	If Under	24 Hrs	100000		Montgom		<i>(2)</i>	
	Funeral Director		5. Social Security N 229-03-74	445	6. Sex 1 □ N	4 2 🖾 F	85	last birthday, Yrs.	Months		Hours	Min.	8. Date of B (Month, D Mar 19	av. Year) (Country)	(State or F	-oreign
	and w		Usual Residence of 10a. State	f Decedent 10b. County			10c. Cit	y, Town or L	ocation							10d. I	Inside City I	Limits
	Maryl f aho	ō	Maryland	Montg	omers	7	Gar	ithers	hura							1	1 X Yes 2	! □ No
	r 288	Director	10e. Street and Nu		omery	<u> </u>	Ga	Leners	10f. Zi	Code				10g. C	itizen of What	Country?		-
	death with the Maryland me 23a or 28a-f ahow curust be confiled at	aiD	101 Oder	ndhal A	venu	e #912			208	377				Uni	ted Sta	tes		
	r dea	Funeral	11. Marital Status		12	. Was Decede Armed Force		.S. 13.	Was Dece	dent of H	ispanic Or in, Mexica	rigin? (Sp	ecify Yes or No Rican, etc.)	lo-	14. Race - Ar Black, W		ndian,	
36	be filed within 72 hours after death with the Marylar lat Hygiene. Ad other than "natural", or itema 23a or 28a-f ahow avent, the Medical Exertiner must be confilled at	by Fu	1 Never Marr			1 ☐ Yes 2 If Yes, Give Year or Date			1 ☐ Yes	2 🔀 No	Specify	:			Specify: W			
ခို	natural',	edt		15. Deceden				16a. Dece	dent's Usu	al Occup	ation			16b. I	Kind of Busines		ry	
215	hin 72 Bin na Medit	Completed	(Spec	cify only highe			or 5+)	(Give	kind of wi	ork done d se retired	during mo: ()	st of work	king				,	
21,	or the	Com	12	ondary (0 12)		- College (, -		Homen	naker					Own	n Home			
pu	2 should be liled within 72 hc and Mental Hygiene, is marked other than 'natur aumatic avant, Ine Medical	Be (17. Father's Name	(First, Middle,	Last)								e (First, Midd	e, Maide	n Sumame)			
<u> </u>	should Ind Meni	ဥ	Joseph 1					T			Miri							
Baltimore, Maryland 21215-0036	permit. Pages 1 end 2 should be Department of Health and Menta Important: If item 27 is marked any injury of other traumatic avonce.		19a. Informant's N Charles				uca)	4	_						or Town, State rsburg,			,
ق _	1 end Health tam 27		20a. Method of Dis		IIIILE	(Spo	20b. F	Place of Disp	osition (Na	me of	!		Date	-	Location - City			
Ω	Pages nent of I		1 ☐ Burial 2 4 ☐ Donation	☑Cremation		noval from St	are l	emetery, cre			· .	. Q/1	30/2006		xandria			า๋อ
Ħ	permit. P Departme Importan any injur		21. Signature of Fu			^	Me	2	2 Name a	nd Addres	ss of Facil	lity De	eVol Fu	nera	1 Home	1, V.	rrgrii.	La
B	Page 4		> Cu	rter	Ç,	Dai	1	G	0 Eas aithe	t De rsbu	er Pa rg, N	ark I MD 20	Prive 1877					
			23a. Part1. Enter I	the disease, or	r complica	tions that can	ed the deat							arrest,		Ap	proximate erval Setwe	en
	Physician		Immediate Cause disease or condition	(Final				ST	ROK	25						9n	erval etwe	7
\mathbf{T}	/Medical Examiner		resulting in death)			Due to (or	as a conseq	juence of):									/	
5	Examiner	-	Sequentially list co	onditions,	b	Due to for	as a cons	uence of										
0	ted	Examiner	if any leading to in cause. Enter Under Cause (Disease or	r injury	ζ	Due to to	as a consign	mence original										
"0 O -	execunand nandial-tra	Exar	that initiated event resulting in death)		C.	Due to (or	as a conseq	juence of):								+	<u>-</u>	
1/06/2 8760,	ate be executed thysiclen and the burial-transit	dicail			d													
1, 6	Tifficat ng phy as th		15.55144.5															
4√7 Box	The law requires thet the death certification has been signed by the attending page 2 should be deteched for use as	by Physician/Me	IF FEMALE: 23b. Was deceder		230	: If yes, outco	me of pregna		⊒€ctopic p	regnancy	,				23d. Date of	-	. Was	
`	ie deat	sici	in the past 12	X No			nt at time of d		Other (s						Month	Day	y Yea	ar
7 o.	thet the	Phy	9 ☐ Unknowr Part II. Other signi		one contr	buting to dog	th but not so	witing in the	undo chiin -		on in Dad		220 Die	Ltobacco	use contribute	to the o	auco of doa	ath?
म् श	uires ti signe	b	Part II. Other signi	incant conditi	OH'S COINT	louting to dea	un but not res	sutting in the	muenying	cause giv	en in Part	1.			V		4 Uni	
Records,	w requ	Completed																
Q S	The lav	I di											24a. We aul	opsy formed?	death	?	findings ave etion of cau	use of
Vital		e Co	25. Was case refe	rred to medica	1						of Disc	1 Daa	1 Tes	2/3 N	lo 1□Y	es 2] No	
V_=	Physician: rthis certificate director,	0 B	examiner?			spital:	patient 2	ER/Outpatie	nt 3 D	Oth Oth	00		th <i>(Check onl</i>) ome 5 □ Be		6 ☐Other (S	neciful		
7 0	ding Phys	ı.	27. Manner of Dea			28a. Date of (Month,		28b. Time (28c. Injur Wor		-	28d. Describ			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
Ϋ́	ttending death. stor: After	atic	1 Natural 2 Accident		gation	(11121111)		,,	М		Yes 2	No						
Division Division	or Attu ofter de Directo in by ti	Certification	3 Suicide 4 Homicide	6 ☐ Could detern		28e. Place o building	f Injury - At h	ome, farm, s	treet, facto	y, office			28f. Location City or 7	(Street a	and Number or ite)	Rural Ro	oute Numbe	э <i>г</i> ,
7 0	pital o		00- C-48	X 0							4.							
10	To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: After th completely filled in by the tunerel	Medicai	29a. Certifier (Check only one)	2 Medical	Examine	r: On the bas and manne	is of examina	ation and/or i	un occurred nvestigatio	at the tir n, in my o	πe, date a pinion, de	ind place. ath occur	, and due to the time	e cause(e, date a	s) and manner nd place, and c	as stated lue to the	o. e cause(s)	
1	To the within 2 To the complet	Me	29b. Signature and	d title of certific	r n n	Λ	0.		29	c. Licens	e number	_	10/	29d. D	ate signed (Mo	onth, Day	(Year)	- · ·
				2		JOL	4			I	14.	25	18		Hugh	lst-	27,0	L00K
	>		30. Name and add	fress of person	who com	pleted cause	of death (Iter	п (83а) (Туре	, Print)	D.	100	7	Dan - 12	- · ·	J-711	NO	000	-7
_			Q.C	HAR	UAN	1,11	114	ron	wu	201	vo /	1	U FCU	al	0 101	100	060	5 0
		ate	31. Date filed (Mor	AUG 2		32. Re	strar's Signa	ature	docal	5								
	Regist	ar		AUU A			CAECAR	~ /										

			For State Registrar	State of M	laryland / De	partment of	of Health and of Death	Mental Hygie	ene 2006	29175	
· ·			1. Decedent's Name (First, Middle, La	st)				2. Date of Death Month	Day Year	3. Time of Death	
	Physicia /Medic		Samuel Edwar	d Tyler				August	22,2006	11:15A ^M	
	Examin	er	4a. Facility Name (If not institution, giv				wn, or Location of Dea	th	4c. County of Death		
		San J	VA Maryland He		ce Syste		y Point	S 9 Date of Righ	Cecil	place (State or Foreign	
田	Funeral Director			Sex 7. A 1 5 M 2□ F	96 (<i>in yrs. iast birtho</i> 72	Months D	ays Hours Min	. (Month, Day, Y		ntry)	
Q B	-4f		Usual Residence of Decedent		12			Dec. 1,	1933 Mary	yland	
amn	Maryland -f ehow [ied at		10a. State 10b. County		10c. City, Town o				1	0d. Inside City Limits	
Sa	Ma-f	ctor	MD Cecil			North	n East			1XYes 2 No	
4	or 28a	Director	10e. Street and Number			10f. Zip Co		10g	. Citizen of What Cour	itry?	
J.e.	ath w	ral	114 North Main S				21901		USA	and the discount of the state o	
${}^{\mathrm{T}}\!$	er de	Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married	12. Was Decedent Armed Forces 1 X Yes 2	t Ever in U.S.	If Yes, specify	t of Hispanic Origin? (Cuban, Mexican, Pue	rto Rican, etc.)	14. Race - Americ Black, White,		
an: 0036	urs afi	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 Yes 2 🔀	No Specify:		Specify: wh	ite	
j a	be filed within 72 hours after death ital Hygiana. id other than "natural", or freme 23 event, the Maulcal Examinar mus	ted	15. Decedent's E	ducation	16a D	ecedent's Usual O	ccupation	16	ib. Kind of Business/In	dustry	
ici 215 -	thin 7	adr.	(Specify only highest grant Elementary/Secondary (0-12)	College (1-4or	5+) (C)	e. DO NOT use r	done during most of wo etired)	Siking			
$\frac{Y}{21}$	ed will ygien ser th	Completed	10			merchant			transportat	ion	
Ph ind	be fill	Be	17. Father's Name (First, Middle, Last	")				ame (First, Middle, Ma			
ر <u>ح</u>	should be nd Mental marked c	2	Oliver Tyler 19a. Informant's Name/Relationship (Time (Print)	10h h	Indian Address (C		Virginia A	Shton Dity or Town, State, Zip	Codal	
to Physician: Maryland 21215-0036	Cl a = =		Barbara Mowbray	•		,					
Š ė,	1 and Health Iem 27		20a. Method of Disposition	SISU	20b. Place of D	isposition (Name	of	. Cambrid Date 20	c. Location - City or To		
ie Known Baltimore ,	ages ant of it: If i		1 ⊠ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specia		9	crematory or other	ns Cem. 8,	/25/06 H	urlock, MD		
=	permit. Pages Department of Important: If it eny injury or o	i	21. Signatur of Funeral Service Lice		PALYTAIR				eral Home H	P.A.	
ag B	Departimonal Important in Succession of Succ		I thut len			700 Locu		ambridge, I		3	
Name Ba			23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between								
	Physician		Immediate Cause (Final disease or condition		oma of	lung				Onset and Death unknown	
	/Medical		resulting in death)		s a consequence of)					dikilowii	
	Examiner		Sequentially list conditions.	b							
7	sit sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or a	s a consequence of)						
	be executed sician and burial-transit	хап	that initiated events resulting in death) Last	c. Due to (or a	s a consequence of)						
760,	te be e ysician ie buriz	calE	· ·	d							
687		_		_ U.							
X	Physician: The law requires that the death certifica this certificale has been signed by the attending phral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregnancy 2 Fetal death	3 □Ectopic pregr	nancy.		23d. Date of delive	,	
.00	deat de atte	S C S	in the past 12 months? 1 Yes 2 No		at time of death	5 ☐ Other (special			Month	Day Year	
9.0	that the de ned by the a detached f	Phy	9 Unknown						1	44.00	
s,	res tha signed be det	þ þ	Part II. Other significant conditions	contributing to death	but not resulting in th	ie underlying caus	se given in Part I.	1	cco use contribute to the		
orc	w require been sign	Completed									
ec	e law has b	npldu.						24a. Was an autopsy performe	prior to co	psy findings available mpletion of cause of	
<u>m</u>	r. Th							1 ☐ Yes 2	No 1 □ Yes	2 No	
Zi.	sician: The law s certificete has b frector, page 2 s	o Be	25. Was case referred to medical examiner?	Hospital:		-0	Othor	eath (Check only one)			
of	ding Phys		1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inpat 28a. Date of In (Month, D			Injury at	28d. Describe how	ce 6 Other (Specification)	v)	
On	Attending in death.	tlor.	1XNatural 5 ☐ Pending 2 ☐ Accident investigation		a <i>y Year)</i> Inju	Iry M	Work? 1 ☐ Yes 2 ☐ No				
Division of Vital Records, P.O. Box	f or Attendated after death Director:	lf Ca	3 Suicide 6 Could not be determined	286. Place of It	njury - At home, farm	, street, factory, or	ffice	281. Location (Stre	et and Number or Rura	ıl Route Number,	
ă	s afte	Certification:	Tiomicas	building, e	нс. (эрвспу)			City of Yours,	01010)		
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificete his completely filled in by the funeral director, page								se(s) and manner as s e and place, and due to		
	the H in 24 the F	Medical	one)	and manner s	stated.						
	To Too	-	29b. Signature and title Certifier	T/11.	/	290. 0	cense number	290	I. Date signed (Month,	way, real/	
			March	4/Men	MO		20390	Αι	igust 22.	2006	
			30. Name and address of person who				th Cama	Suatom Da	nnu Dain	+ MD 2190	
1	Sta	ite	Charles Hoesch 31. Date filed (Month, Day, Year)	32. Reg	trar's Signature	_		oyacem re	-rra LOTH	C 11D 2130	
11023	Dogist				and the	A. M					

		1	For State Registrar	State of Marylar	nd / Depa <i>Cel</i>	artmen <i>rtificat</i>	t of H e <i>of L</i>	ealth and D <i>eath</i>	Mental Hy	/giene Reg. No.	2006	29176		
			1. Decedent's Name (First, Middle, Last)						2. Date of D Month	eath Day	Year	3. Time of Death		
	Physicia /Medic	al	Major Roosevel						22-20		4:45 am			
>	Examin		4a. Facility Name (If not institution, give	street and number)				Location of Dea		4c. C	h			
			706 Etna Drive 5. Social Security Number 6. Sec	x 7. Age (In yrs.	last birthday)		1 Year	arlbor		irth	PG 9. Birtl	hplace (State or Foreign		
	Funeral Director			JM 2□F 76		Months	Days	Hours Min	s. 8. Date of B n. (Month, D 05/12	$\frac{2}{1}$	0 0	hplace (State or Foreign untry) NJ		
	D		Usuel Residence of Decedent									40d Inside City Limits		
1215-0036	arylan show	_	10a. State 10b. County	10c. Ci	ty, Town or Lo Upper		·1ho	ro				10d. Inside City Limits 1 X Yes 2 ☐ No		
	Ba-f	ecto	MD PG		opper	10f. Zip				10g Citiz	en of What Co	untry?		
	a or 2	Funeral Director	706 Etna Drive				2077	4		_	. A .	y .		
	ne 23	era	11. Marital Status	12. Was Decedent Ever in U	J.S. 13.	Was Dece	dent of H	ispanic Origin?	(Specify Yes or N		4. Race - Ame			
(O	or iter	Fun	1 Never Married 20 Married	Armed Forces? 1 ∑Yes 2 □ No		If Yes, spe		n, Mexican, Pue Specify:	erto Hican, etc.)		Black, White Specify: Bl	_		
ĕ	ours a	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:					·					
5-0	72 h	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)	16a. Dece (Give	dent's Usu	al Occup	ation during most of w	rorking	16b. Kin	d of Business/	Industry		
12	within and the state of the sta	du	Elementary/Secondary (0-12)	College (1-4or 5+) + 2	Comp	puter	Sp	eciali	st	U.S	Gov	erment		
Maryland 21215-0036	Hygie Hygie ther		17. Father's Name (First, Middle, Last)	T Z				18. Mother's N	ame (First, Middi	e, Maiden S	Sumame)			
au	ld be ental ked c	To Be	William Upsor	1			i	Ophel	ia Gil	liam				
ary	shou and M mar umat	F	F	Ĕ	19a. Informant's Name/Relationship (T)	rpe, Print)		•			Rural Route Num			
Ξ	and 2 selth a 127 i		Frances Upson/					. Uppe	r Marl	-				
ore,	of He		20a, Method of Disposition 1 Burial 2 □ Cremation 3 □ F	Ramaural from State	Place of Disponentery, cre	matory or	other plac	e) 0./0	Date	1	cation - City or			
Ĕ	Pag ment tant:		4 ☐ Donation 5 ☐ Other (Specify)	, H-1	ncoln							Maryland		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Department of Heelth and Mental Hygiene important: if Item 27 is marked other then "naturel; or iteme 23a or 28a-f show important: if Item 27 is marked other then "naturel; or iteme 23a or 28a-f show eny injury or other traumatic event, it a Medical Examination must be notified at once.		21. Signature of Funeral Service Doen	audor					aylor's			DC 20002		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between											
	Physician		Immediate Cause (Final disease or condition resulting in death) a. — Multiple Myeloma Due to (or as a consequence of):									Onset and Death 18 months		
	/Medical Examiner													
	Examine													
	led sit	Examiner	If any, leading to immediate cause. Enter Underlying Cause Disease or injury											
	al-tra	xar	that initiated events c											
8760,	death certificate be executed e attending physicien and nd for use as the burial-transit	dical		d								211		
9	tificati g phy as th	led				373000		-000						
Вох	th cer endin	by Physiclan/Me	23b. was decedent pregnant	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fel		□Ectopic p	regnancy	,		2	3d. Date of de Month	livery Day Year		
	0 0	sick	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of 9☐ Unknown	death 5	Other (s	pecify)				WIGHT	Day 1 Sai		
P.O.	requires that the death cer een signed by the attendir hould be detached for use	Phy	9 Unknown Part II. Other significant conditions co	entributing to death but not re	sculting in the	underking	ratise div	en in Part I	23e. Dio	i tobacco u	se contribute to	o the cause of death?		
	8 6 0		Part II, Other significant conditions co	microuning to death but not re	authing in the t	underlying.	Jauss giv	or are are a		Yes 212		robably 4 Unknown		
Ö	w require been signal	Completed							24a. W		24h Ware a	utopsy findings available		
360	he ta	ם							–	topsy rformed?	prior to death?	completion of cause of		
a		ပို	25. Was case referred to medical	1				26 Place of [1 Yes	AT THE R	1 L Yes	s 2□ No		
₹	Physician: this certific ral director,	To B	examiner?	Hospital: 1 Inpatient 2[☐ ER/Outpatie	ent 3□ D	OA Ott	or	g Home 5⊠Re		3 □Other (Spe	ecify)		
			27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time	of	28c. Injui Wor	y at	28d. Describ	e how injury	y occurred			
	Attending I r death. ector: After by the funer	ertification:	atlo	1 Natural 5 Pending 2 Accident investigation			М	1 🗆	Yes 2 □ No					
Ν	l or Atten after deat Director: I in by the	Ę	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, s cify)	treet, facto	ry, office			ion (Street and Number or Rural Route Number, or Town, State)				
	lospital of hours af uneral D	O	CO. Codiling 1 Tr Cortifying Ph	ysician: To the best of my kr	anuladae des	ith occurre	d at the ti	me date and nic	ace, and due to th	o causo(s)	and manner a	s stated		
	T 4 T 2	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Examone)	iner: On the best of my ki and manner stated.	nation and/or i	nvestigatio	n, in my	opinion, death of	ccurred at the tim	e, date and	place, and du	e to the cause(s)		
	To the within 2 To the complet	Me	29b. Signature and title of certifier	a 1 A		1		se number			e signed (Mon	•		
			> W could	CILVA	1/2		0003	7529		08/2	24/200	6		
0	(10/		30. Name and address of person who	completed cause of death (It	em 23a) (Type	, Print)								
15	0		Ronald C.Wheele			le La	ane	Largo,	MD 207	74				
		ate	31. Date filed (Month, Day, Year) AUG 2 8 200	37 Registrar's Sig										
	Regist	UE*II	1 4111 ₅ 2 7 /1181	13 M. A. S. S. S. S. S. S. S. S. S. S. S. S. S.	- 437									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Day Month Year **Physician** ам 2006 Thomas N.Wright August 24 6 • 55 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Feb, 18 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1**⊠**M 2□F Yrs. 67 Director 578-52**-**9<u>78</u>2 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County in then "natural", or iteme 23e or 28e-f show the Medical Examiner must be mailfied at 1 Yes 2 □ No Mt. Rainer Mont Md. Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20712 4306 31st Street death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status e filed within 72 hours after all Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify:Black þ 3 ☐ Widowed 4 S Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) US Postal Service Postal Worker 2yrs es 1 and 2 should be filed voll Health and Mental Hygis of Health and Mental Hygis filem 27 is marked other tother traumatic event, to 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Tapscott Wynyard Thomas N.Wright ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 4306 31st Street Mt. Rainer Maryland 2 0712 Michael T. Wright (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Importent: if ite 08-30-2006Riverdale Md. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Riverdale Pk.Crem 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 719 Kennedy St. NW Wash, DC 20011 23a. Part1. Enter the disease, or complications that shock, or beart failure. List only one cause on Approximate Interval Between Onset and Death o not enter the mode of dying, such as cardiac or respiratory arrest, caused the death, Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Colon Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinite late cause. Enter Underlying Cause (Disease or injury that initiated events Que to for as a consequence of Examine anding physician and use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ed by the a Records, P.O. 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 ☐ Yes 2 ☐ No 1 Yes 2 X No Division of Vital Physician: s after death.
I Director: After this certifica of in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: or Attending Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 3 ☐ Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide To the Hospitel o within 24 hours aft To the Funerel Di completely filled in 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in my opinion, death occurred at the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifien 8/25/2006 Doo61887 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20910 Dr.Rabin Md. Holy Cross Hosp. 1500 Forest glen Rd, Silver Spring 32. Registrar's Signature 31. Date liled (Month, Day, Year) State AUG 3 0 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 2006 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Katherine August 24 2006 Elsie Wofford 10:19a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring
If Under 1 Year | If Under 24 Hrs
Months | Days | Hours | Min. Montgomery 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛱 F Yrs. Director 147-26-1626 June 19, 1935 Virginia Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f ahow 1√2 Yes 2 □ No Funeral Director Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20904 13236 Old Columbia Pike death , 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 'natural', or itama 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Bi-Racial Š 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Registered Nurse Private permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: if item 27 is marked othiny injury or other traumatic avant, 9068. 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ivanhoe J. Morse Elsie L. Rose 19a. Informant's Name/Retationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13236 Old Columbia Pike Silver Spring, MD John C. Wofford / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 8/29/06 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Gardens Rockville, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, MD Approximate Interval Between Onset and Death 23a. Part1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Liver Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Coagulopathy Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Sepsis that initiated events resulting in death) Last Due to (or as a consequence of): ettending physicien a for use as the burial-Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the e 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐ Yes 2 \ No 1 Yes 2 No the Hospital or Attanding Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 📉 No 1 fnpatient 2 ER/Outpatient 3 DOA ၉ this 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification 5 Pending investigation 1 X Natural 1 Yes 2 No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) 4 Thomicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Light Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifies Medical and manner stated within 2 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) sull 2 050987 Name and address of person who completed cause of death (Item 23a) (Type, Print) Po Box 83819 Gailhers burg AHMED NAWAL 31. Date filed (Month, Day, Year) State Registrar AUG 3 0 2006

	ŭ.		1 - For State Registrar	State of Maryland / D	Depa <i>Cen</i>	rtment of He tificate of L	ealth and Death	Mental Hy	giene 2 Reg. No.	006	29179	
- W	Physici /Medic		1. Decedent's Name (First, Middle, Las Albert	Williams				2. Date of De Month August	Day 17,	Year 2006	3. Time of Death 8:49 A M	
	Examin		4a. Facility Name (If not institution, give 4002 Lyons Street		4b. City, Town, or Location of Death Temple Hills			4c. County of Death Prince Georges				
***	Funeral Director		5. Social Security Number 6. Security Number 248-46-8057	5	thday) Yrs.	Months Days	If Under 24 Hrs Hours Min.		y, Year)	Coun	lace (State or Foreign try) da, SC.	
Maryland 21215-0036	he Maryland Ba-f ehow	Director	10a. State 10b. County Maryland Prince G	eorges 10c. City, Town Temp1					10g Citizon	of What Coun	0d. Inside City Limits 1 🛣 Yes 2 🗆 No	
	with the		10e. Street and Number 4002 Lyons Street			20748				d State		
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or fleme 23s or 28s-1 show aumatic event, I'm Medical Evanting rings by swiffled at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Midowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes. 2 ☑ No If Yes, Give Year or Dates:		/as Decedent of Hi. Yes, specify Cubar	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		Race - Americ Black, White, ecify: B1		
	vithin 72 horne. ne. han "naturi Medical	Completed	15. Decedent's Ed (Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give k life. D	ent's Usual Occupa kind of work done d OO NOT use retired,	uring most of wa	rking		of Business/Ind	dustry	
2	Hygiel Hygiel ther th		8th 17. Father's Name (First, Middle, Last)	Co	onst	ruction V		me (First, Middle		rivate mame)		
<u>lan</u>	Aental Aental rked o	To Be	John Williams				Essi	e Graham	1			
Mary	ges 1 and 2 should t of Health and Men If Item 27 is marke or other traumatic		19a. Informant's Name/Relationship (7 Loretta Williams-			Address (Street a				own, State, Zip 0735	Code)	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra <u>once</u> .		20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State cemeter	ry, crem	sition (Name of latory or other place Lvet Cemet		Date 25, 2006		ion - City or To		
Balti	permit. Departm Imports any Inju		21. Signature of Funeral Service Licen	Tikel!	22.	Name and Addres	s of Facility	Pope Fur 5538 Mar Forestvi	neral H lboro	Homes, Pike	1747	
8760,	Luysicien and // // // // // // // // // // // // //	ysician/Medical Examiner	Physician/Medical Examiner	23a. Part 1. Enter the disease, or compshock, or heart failure. List only of limits of the condition resulting in death) Sequentially list conditions, 3.1 basing to minustrate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	of):	e Cara				Dis e	Approximate Interval Between Onset and Death
P.O. Box 6	The law requires that the death certific at the Seen signed by the attending page 2 should be detached for use as			ysician/Me	ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 9□Unknown		Ectopic pregnancy Other (specify)			23d
Ś	w requires that to be by should be detail	ρ	Fait II. Other significant continuous continuous to death out not resouring in the discontinuous great in act.									
Division of Vital Record		Completed			_			24a. Was auto perfe 1 Yes		24b. Were auto prior to co death? 1 ☐ Yes	opsy findings available impletion of cause of	
Vita	victan: Th certificate rector, peg	Be	25. Was case referred to medical examinet?	Hospital:		Othe	ar	ath (Check only				
on of \	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification completely filled in by the funeral director.	tion: To	1. ✓ Yes 2 ☐ No 27. Manner of Death 1 ③ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	utpatien Time of Injury	28c. Injun	4 Nursing	Home 5 K Res 28d. Describe			(fy)	
Divisi	al or Atten s after dea l Director d in by the	Certification:	3 Suicide 6 Could not be determined	DB Class of lawn. At home farm street feature office. 28f					3f. Location (Street and Number or Rural Route Number, City or Town, State)			
	ne Hospital of 24 hours and Funeral Dietely filled is	edicai C	29a. Certifier 1 Certifying Ph (Check only 2 Medical Example)	ysician: To the best of my knowledge tiner: On the basis of examination are and manner stated.	e, death	occurred at the time vestigation, in my of	ne, date and place pinion, death occ	e, and due to the curred at the time	cause(s) an , date and pla	d manner as s ace, and due to	stated. o the cause(s)	
	To the To the Comp	Me	29b. Signature and title of certifier	11 -+		29c. License			29d. Date s	signed (Month.	Day, Year)	
•			the sode ,	12/2/2 Do		13	0055	727	Aug	345/2	2, 2006	
R			30. Name and address of person who	mpleted cause of death (Item 23a)	(Type,	Print) Dital I	Drive.	Clove	J. 1	ray/c	Bod	
	St Regist	ate rar	31. Date filed (Month, Day, Year) AUG 3 0 2006	2. Registrar's Signature	for	E)			0/	0		

		1 - For State Registrar	State of Mary		artment of tificate of			ene 2006	29180	
Physicia /Medic	al	Decedent's Name (First, Middle, Last Edwin J. Waites 4a. Facility Name (If not institution, give)			Ah Cihi Taur	or Location of Death	2. Date of Death Month 08	Day Year 17 2006	3. Time of Death 22:07 PM	
Examin	er	Suburban Hospital			Bethesd	la		Montgomer	<u> </u>	
Funeral Director		5. Social Security Number 6. Se 151-24-3895 Usual Residence of Decedent	x 7. Age (In 74	yrs. last birthday) Yrs.	If Under 1 Yea Months Days	s Hours Min.	8. Date of Birth (Month, Day, March 1(9. Birth Cou 1932	place (State or Foreign ntry) NJ	
deeth with the Maryland me 23s or 28s-f ehow crivat be notilised at	jor	10a. State 10b. County DC		ashingto					10d. Inside City Limits 1 ☐ Yes 2X No	
3e or 28e	Funeral Director	10e. Street and Number 1629 Columbia Rd			10f. Zip Code 2000			og Citizen of What Cou United Stat	•	
or ite	ρ	11. Marital Status 1 Never Married 2 Married 3 Widowed	12. Was Decedent Ever Armed Forces? ₩ yes 2 No If Yes, Give Year or Dates:	1	Was Decedent of f Yes, specify Cu	Hispanic Origin? (Speban, Mexican, Puerto For Specify:	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: B		
E II	Completed	15. Decedent's Edu (Specify only highest grad	cation le completed) College (1-4or 5+)	(Give life. L		e during most of working ed)	19	66. Kind of Business/In	dustry	
Item 27 is marked other then other treumatic event, I'm M	To Be Co	12 17. Father's Name (First, Middle, Last) Edwin J. Waites,	Sr.	Trans	portatio	n Speciali 18. Mother's Name Elonora	(First, Middle, M	faiden Sumame)		
if Health and Mental Item 27 is marked o other treumatic ev		19a. Informant's Name/Relationship (7) Tara Waites/daugh	ter	5638	Emerson	St #B6, B1	adensbui	City or Town, State, Zig	0	
nlury or		20a. Method of Disposition 1 XBurial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens	Removal from State	ock Cree	matory or other pl k Cemete	ery 08-25	-06 V	Nashington,	DC	
b a		Pman	shall			421	7 9th St	Funeral Ho t NW, Wash.		
sician edical		23a. Part Sher the disease, or compi shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a. Sepsi	S.	er the mode of dy	ring, such as cardiac or	respiratory arre	st,	Approximate Interval Between Onset and Death	
xaminer	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury	b. acute Due to (or as a cor	Sequence of):	l fail	488.		>	Days	
ysicie	ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. acute Hepatic fallwre Die to (or as a consequence for): Die to (or as a consequence for): Die to (or as a consequence for): Xeax							
ettending p for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of proceedings of proceedings of the control	Fetal death 3	Ectopic pregnand Other (specify)	су		23d. Date of deliver	ery Day Year	
should be detached	ρ	Part II. Other significant conditions con	art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. OWNCES LIVINARY BLADLER						he cause of death?	
page 2 sho	Completed	Cancer L	ung brilah	24a. Was ar autops; perform					sy prior to completion of cause of med?	
this c	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 1 27. Manner of Death 1 Notatural 5 Pending 2 Accident investigation	Hospital: 1 Anpatient 28a. Date of Injury (Month, Day Yea		ne 5 ☐ Resider	nce 6 ⊡Other (Specil w injury occurred	y)			
rs efter des ai Director ed in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - a building, etc. (Sp	pecify)			City or Town,			
the Hospital in 24 hours e the Funeral I npletely filled	Medical	one)	sician: To the best of my ner: On the basis of exar and manner stated.	knowledge, death mination and/or inv	estigation, in my	opinion, death occurre	d at the time, da	te and place, and due to	the cause(s)	
To To Cool	2	29b. Signature and title of certifier	0.,		1019	609	29	d. Date signed (Month,	Day, Year)	
(5)		1-01	WN ROA	D Suite	Print) RA	MAN K	urg. N	UI. MI)	3	
Sta Registra		31. Date filed (Month, Day, Year) AUG 2 9 2006	. Registrar's S	k L	<i>P.</i> 1					

06-06785 Please Type or Print in Black Indelible Ink Craig Willis State of Maryland / Department of Health and Mental Hygiene 2006 2918 1- For State Certificate of Death Reg No Reuistrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day September 8, 2006 Medical Examiner 2135 hrs Craig Richard Willis 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c County of Death 289 East Main Street Apartment 2 Frostburg Allegany If Under 1 Year | If Under 24Hrs | 8 Date of Birth (MM/DD/YYYY) 9 Birthplace (State or Foreign Maryland 5 Social Security Number 6 Sex **Funeral** 7. Age (In yrs. last birthday) Director 1 X M 2 F 217-17-4019 12/18/1980 Usual Residence of Decedent 10c City Town or Location 10d Inside City Limits MD Allegany Frostburg 1 XYes 2 28a-f shov after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 289 East Main Street, Apt #2 21532 Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14 Race - American Indian Black st be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No Yes If Yes. Give Year Widowed Yes 2 X No specify: 4 Divorced Specify: White ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Waiter Restaurant 17 Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) event, t Eugene Willis Cheryl Jean 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James E. Willis / father 10101 Keatley Drive, LaVale, Maryland 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town State crematory or other place) Burial 2 X Cremation 3 Removal from State Cumberland Crematory 09/12/2006 Cumberland, MD Donation 5 Other Specify 21 Signature of Funeral Service Licensee, 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 23a Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interva failure. List only one cause on each line Between Onset and /Medical Death Methadone and alcohol intoxication Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Examine if any, leading to immediate nause. Enter Underlying Gauss Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical X UNPENDED item#23a,27,28a-f,perME,g860,10/2/06 TT Division of Vital Records, P.O. Box 68760 23c. If ves. outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth Month Fetal death Year Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a Was an 24b Were autopsy findings available prior to completion of cause of death? autopsy performed? ✓ Yes 2 No 1 🗸 Yes 25 Was case referred to medical To the Bospital or Attending Physician: 26 Place of Death (Check only one) Be Other₄ Hospital: 1 Inpatient FR/Outpatient 3 Nursing Home 5 Residence 6 V Other Scene 1 V Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after www...

To the Fineral Director: A Natural 5 Pending 1 Yes 2XX No Fnd 9/8/2006 Fnd 9:05 pm unk 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 289 East Main Street Apt #2, Frostburg, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be Suicide determined (Specify) found at home Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b Signature and title of centifie 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E September 9, 2006 on who completed cause of death (Item 23a) 30 Name and address of per Deputy Chief Medical Examiner Jack Titus MD. 111 Penn Street, Baltimore, MD 21201 egistrar's Signatur

State

Registrar

2006

Please Type or Print in Black Indelible Ink

obert Williams	State of Maryland / Department of Health at	nd Mental Hygiene
Physiciar	1. For State Registrar Certificate of Death 1. Degedent's Name (First, Middle, Last)	Reg. No 2006 29 8
Medical Examin	KODERT Williams	Month Day Year 2330 hrs
	Peninsula Regional Salisbury	or Location of Death 4c. County of Death Wicomico
Funeral Director	5. Social Security 1960836 6. Sex 7. Age (In yrs. last birthday) If Under 1 Ye	
v any	Usual Residence of Decedent 10a. State 10b. Coupty 10c City. Town or Location	10d Inside City Limits
the Maryland a or 28a-f show iffed at once.	10e. Street and Number	1 Ves 2 No
ith the 23a or notified	TITO TAMEN / (VO MI)	1853 U.S.A
er death w	1 Never Married 2 Married Armed Forces? If Yes, specify Cuba	ispanic Origin? (Specify Yes or No- in, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 8 lack, White, etc.
ours afte	3	ation (Give kind of work done 16b. Kind of Business/Industry
AD 21215-0036 2 should be filed within 72 hour and Mental Hygiene. 27 is marked other than "natu matic event, the Medical Exar TO Be Committed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life	
215-0 be filed w ntal Hygie rked othe ent, the A		18 Mother's Name (First, Middle, Maiden Syrname) Planthe V MC (all
mnd 2 should be fit and 2 should be fit cealth and Mental Item 27 is marked traumatic event,	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Stre	et and Number or Rural Route Number, City or Town, State, Zip Code)
두 모든 모 때	20a. Method of Disposition 1 Burial 2 Accemation 3 Removal from State Crematory or other place)	metery, Date 20c. Location - City or Town, State
Fag ment ment trant:	4 Donation 5 Other Specify: Sal Soury Creme	
	21. Signature of Funeral Service Licensee Anthony E. Ward, Sr. (per DVR) 23a Part I Enter the disease of complications that source the death Part I	
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying failure. List only one cause on each line. Immediate Cause (Final disease a Acute asthma exacerbation	such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death
	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.	
ted Insit	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated	
ecuted and transit	events resulting in death) Last Due to (or as a consequence of): d.	
60, ate be exe hysician be burial -	d. X UNPENDED X AMENDED item#23a,27,perME,g859,9/12/ item#5.21.perFH,G859,9/13/	06 TT// #5.perFh. G863, 1/16/07 TT
J. Box 68760, the death certificate be executed by the attending physician and ched for use as the burial - transit Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5 Other (Specify)	23d. Date of delivery Month Day Year
O. Bo trthe deat by the at ached for Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause of	given in Part I. 23e. Did tobacco use contribute to the cause of death?
IS, P.O. quires that the		1 Yes 2 No 3 Probably 4 V Unknown
Division of Vital Records, also ratending Physician: The law require is after death. al Director: After this certificate has been siled in by the funeral director, page 2 should be rification: To Be Completed		24a Was an autopsy performed? 24b Were autopsy findings available prior to completion of cause of death?
Vital Rec ysician: The his certificate director, page		1 Ves 2 No 1 Ves 2 No
n of Vision of Oliver of the control	1 V Yes 2 No Postition 1 Inpatient 2 FR/Outpatient 3 DOA	Other ₄ Nursing Home 5 Residence 6 Other: ry at Work? 28d Describe how injury occurred
Sion Attendin r death. ector: A by the fu	2 Accident Investigation 1	res 2 No
Division (spital or Attending hours after death. neral Director: After filled in by the fun Certification	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office b	uilding, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Division of Vital To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certificantly filled in by the funeral director. Medical Certification: To Be (29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, da one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, and manner stated	te and place, and due to the cause(s) and manner as started. , death occurred at the time, date and place, and due to the cause(s)
F % F % P & P	29b. Signature and title of certifier 29c. License	and digited (widhili, Day, rear)
	30. Name and address of person who completed cause of death (Item 23a)	VI.E. July 19, 2006
State	Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, B 31. Date filed (Month, Day, Year) 32 Registrar's Signature	altimore, MD 21201
Registrar		

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of H rtificate of L	ealth and M Death	ental Hygie	ene 2006	29183
	Physici		Decedent's Name (First, Middle, L WILLIAM	FREDRICK	WAGNI	ER		2. Date of Death Month August	^{Day} 23,2006	3. Time of Death 7:15A M
)	/Medio								4c. County of Deat	h
	Funeral Director				e (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	ear) 9. Birti	hplace (State or Foreign untry)
	Aaryland	or	Usual Residence of Decedent 10a. State 10b. County MD Mont	COMerv			σ			10d. Inside City Limits 1 XYes 2 □ No
	vith the N	Director	10e. Street and Number		DIIVE	10f. Zip Code	9	109	. Citizen of What Co	untry?
36	72 hours after deeth with the Maryland Insturet, or items 23a or 28a-f ehow dical Exantiner must be notified at	by Funeral	1827 Idlewood 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Secretary Annable Secretary Secretar						
21215-0036	within ane. than "	Completed by		Education rade completed) College (1-4or 5	16a. Dece (Give life.	kind of work done of DO NOT use retired	ation luring most of workir)	ng 16	b. Kind of Business/	Industry
Maryland 2	be filed htal Hygi ht other event, I	To Be Co	17. Father's Name (First, Middle, Las Clarence Wag	st)					iden Surname)	
	of the article of the	_	· ·		1827	Idlewo	and Number or Rura Od Rd Si	Route Number, C .lverSpr	city or Town, State, 2	
altimore,	0 0	8	4 Donation 5 Other (Spec	eify)	MD Vete	matory or other place rans Cei	m 8/30	/06	heltenha	am. MD
Ball Ball	permit. Pag Depertment Important: i any injury o		14 year	R. K.	11 2	46 N. W.	ashingto	n St Ro	Cvilla	MD 20850
	Physician /Medical Examiner	ı	Immediate Cause (Final disease or condition resulting in death)	Metast Due to (or as Pneumo	tatic Col a consequence of): Onia			r respiratory arrest	,	Approximate Interval Between Onset and Death
8760,	cate be executed physician and the burial-transit	dical Examiner	n any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c						
.O. Box 6	death certifi e ettending d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death 3					,
rds, P	uires tha signed Ild be dei	þ	Part II. Other significant conditions	contributing to death b	ut not resulting in the u	nderlying cause give	en in Part I.			
of Vital Records,		Completed						autopsy performe	d? death?	
ΖÏ	Physician: this certific al director,	To Be	25. Was case referred to medical examiner?	Hospital:	est 2 DEB/Outration	Othe	ar .		0.5304 (0	
ion of	ling After funer		27. Manner of Death 1. Natural 5 ☐ Pending	28a. Date of Inju (Month, Da)	ry 28b. Time o	f 28c. Injury Work	at 2			ny)
Division	ital or Attencts after death et Director:	Certification:		286. Place of Inju	ury - At home, farm, sti c. (Specify)	eet, factory, office	2			ral Route Number,
	To the Hospital or A within 24 hours after To the Funerel Direction places of the Completely filled in by	Medical	one) 2 Madical Exe	iminar: On the basis of	examination and/or in	vestigation, in my op	pinion, death occurre	ed at the time, date	and place, and due	to the cause(s)
	P Som	2	29b. Signature and title of certifier	$m \cdot D$.				29d	1 1	
						,	Glen P	d Silvo		
	Sta Registr		31. Date filed (Month, Day, Year)	32 G egistra	ar's Signature	ali	, GICH IN	W DIIVE	r phriid	151050310

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 - For State Registrate 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 8.34 AM SEP 08 2006 HEN NIE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Agnes Hospital Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** -28-4008 1□M 2XF SOUTH CAROLINA Yrs. Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City. Town or Location 10a. State 10h. County or items 23a or 28a-f ehow the Medical Examiner must be notified at 1 Syes 2 No Directo MARVLAND Og. Citizen of What Country? 10e. Street and Number 31 ASTERY AVENUE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 Yes 28 No Specify. þ 3 ☐ Widowed 4 ☐ Divorced "naturei", Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) BALTO CITY PUBLIC SCHOOLS WORKER Pages 1 and 2 should be filed v timent of Health and Mental Hygie tent: if Item 27 ie marked other t jury or other traumatic event, in 18. Mother's Name (First, Middle, Maiden Sumame)-17. Father's Name (First, Middle, Last) ARSONS ELIJAH ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) EDWAY CIRCLE RANDALISTOWN MD 21133 JANICE REED CDAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Importent: if any injury or once. MD, NATIONAL CEME, 09-15-06 4 ☐ Donation 6 ☐ Other (Specify) JR. FUNERAL HOME 21. Signalor of Funeral Service BALTO, FULTON AVE. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resutting in death) HOURS PULMONARY EMBOLISM Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical use as the Box (IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Ö 9 Unknown 9 Unknown ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ą Records, 1 Tes 2 No 3 Probably 4 Illinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 □ M6 1 ☐ Yes of Vital To the Hoepital or Attending Physician: within 24 hours after death.
To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ 🛪 6 1 Hopatient 2 ER/Outpatient 3 DOA ဥ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: Division 1 PNatural 5 Pendina 1 🗌 Yes 2 No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide

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DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) State 2006 Registrar

29b. Signature and title of certifier

KOLLI RAMESH

K Ramen

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SE AGNES

29a. Certifier

3. Registrar's Signature

MD

HOSPITAL

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

9005

P17602

CATONS

29d. Date signed (Month, Day, Year)

2006

21229

BALTIMORE MD

SEP 08

AVE

ORIGINAL

Physici		1 - For Amend #1 Per Registrar Amend #1 Per 1. Decedent's Name (First, Middle, Last, Lorna Ahlfedit			Ahlf Ahlf	eldt			2. Date of Dea	ath	3, ^{Year} 00	3. Time of Death 5:55 AM M
/Medic Examin		4a. Facility Name (If not institution, give Upper Chesapeake I	street and number) Hospital			4b. City, Town, o	r Location o				ounty of Death	
Funeral Director		5. Social Security Number 6. Sec. 212-34-6077	7. Age	e (In yrs. last 70	birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birt 03/16/	1 ⁹ 36	9. Birth MD	place (State or Foreign intry)
yland		Usual Residence of Decedent 10a. State 10b. County		10c. City, To								10d. Inside City Limits
death with the Maryland me 23a or 28a-f ehow rroant be notified at	Funeral Director	MD Harford 10e. Street and Number		Havre	e De	Grace				10g. Citize	n of What Cou	1 Yes & No
ath with 23a or	ral DI	505 Congress Avenu				21078				USA		
ĕ £ ₹	by	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Was Decedent! Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			Vas Decedent of I Yes, specify Cub ☐ Yes 2 No		gin? (Spe 1, Puerto f	cify Yes or No- Rican, etc.)		. Race - Ameri Black, White pecify: Whi	, etc.
within 72 hours att	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		143	(Give k	ent's Usual Occup kind of work done OO NOT use retire cleaner	oation during mos d)	t of workir	ng		of Business/Ir dential	
Baltimore, Maryland 21215-0 permit. Pages 1 and 2 should be filed within 72 ho permit. Pages 1 and 2 should be filed within 72 ho permiten of health and Mental Hygiene. Importent: if lem 27 is marked other than "natur any injury or other traumatic event, the Madical	To Be Co	17. Father's Name (First, Middle, Last) Harry Schaeffer						er's Name a Bu	(First, Middle,	Maiden Su	итате)	
Mary		19a. Informant's Name/Relationship (T) Candice Boecher/Gra				g Address (Street Westfie						
Iltimore, Maryland int. Pages 1 and 2 should be file artment of Health and Mental Hy actiment of Health and Mental Hy injury or other traumatic event injury or other traumatic event		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify)		ceme	apeak	sition (Name of latory or other pla ce Cremat	tory	2	Sep 13 2006	Belts		own, State Maryland
Ball Departition important in eny in		21. Signature of Funeral Service Licens	ether M	0144		rematushr 717 Green						ryland
Physician /Medical Examiner bhysician and street be executed the purial (ransit tansit).	dical Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to uninediate cause. Enter Underlying Cause (Disease or injury that initiate devents resulting in death) Last	Due to (or as	a consequent	VIC ee of).	/pneu isc	hen	wa				Interval Between Onset and Death
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<u>> v</u> ≈ ₽ 3	þ	Part fl. Other significant conditions co	ntributing to death b	out not resultin	ng in the un	derlying cause gr	ven in Part I			obacco úse Yes 2 🗆		the cause of death?
TOO I Rec The law	Completed	CAD							24a. Was autor perfo 1 🗆 Yes	osy rmed?	24b. Were aut prior to death? 1 \(\sum \text{Yes}	copsy findings available ompletion of cause of
Of Vital F Physician: The this certificate	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2□ER/	/Outpatien	t 3 DOA Ot	hor		n <i>(Check only o</i> me 5 ☐ Resid		□Other (Spec	ıf v)
Ing Ph	lon: T	27. Mann Ceath 1 Natural 5 Pending investigation	28a. Date of Inju (Month, Da	y Year) 28	b. Time of Injury	28c. Inju		2	28d. Describe l			
D :	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	jury - At home c. (Specify)	, farm, stre	eet, factory, office	,,,,,		28f. Location (; City or Tou	Street and i wn, State)	Number or Ru	ral Route Number,
Ahlfel Divis the Hospital or Att in 24 hours after de the Funeral Direct notetiely filled in by it	Medical		sician: To the best ner: On the basis o and manner st	f examination								
To the within To the comple	M	29b. Signatu and title of certifier	9	- /	· .	29c. Licen	se number	11		29d. Date	signed (Month	Day, Year)
5		30. Name and ordress of person who of	ompleted cause of c	death (Item 23	Ba) (Type, I	Print)	mm	OKA	05	611	cmc	21014
St Regist	ate rar	31. Date filed (Month, Day, Year) SEP 1 4 2006	32. Registr	rar's Sidnature			- Harl	A.I.V.		V	11111	

JUNAJOB , LOVELY

			1- State of Maryland / Department of Health and No., C859 09:14/06dhb.	Mental Hyg	giene Reg. No. 2006 29187
E	Physici /Medio	al	1. Decedent's Name (First, Middle, Last) TOSEPHINE 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	2. Date of Dea Month	th Day Year 2.15 PM 4c. County of Death
	Examir Funeral Director	ier	5. Social Security Number 6. Sex 1 Morths 1	8. Date of Birt	N/A
	Be-f show	Director	10a. State 10b. County 10c. City, Town or Location MARYLAND N/A BALTIMORE		10d. Inside City Limits 1 X Yes 2 □ No
36	s 1 and 2 should be lied within 72 hours after death with the Maryland f Health and Mental Hygiene. f Health and Mental Hygiene. other traumatic event, the Medical Examinational be notified at	by Funeral Dire	10e. Street and Number 10f. Zip Code 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 10f. Zip Code 11. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto If Yes, Specify Cuban, Mexican, Puerto If Yes, Give 1 Yes 2 No Specify:		10g. Citizen of What Country? U. 5, A. 14. Race - American Indian, Black, White, etc. Specify: J. H. i. T.E.
12120	nied within 72 hour l'Hygiene. other than "natura ent, the Medical E	e Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+)		16b. Kind of Business/Industry EDULATION - BALTOLIS Maiden Sumame)
	2 should be and Mental Is marked of raumatic ever	ToBe	Joseph Filip 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rur	al Route Numbe	r, City or Town, State, Zip Code)
Baltimore, IN	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		Tose PH BORACKISON 20a. Method of Disposition 1 ABurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility	28'66 1	20c. Location - City or Town, State
	nysician /Medical Examiner	16	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Sequentially list conditions, b. ATRIAL FIRE CRITICAL CRITICAL	or respiratory an	rest, Approximate Interval Between Onset and Death
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L (SDIC	v requires mat been signed by should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use contribute to the cause of death? es 2 No 3 Probably 4 Punknown
		Completed		24a. Was a autop perfor	sy prior to completion of cause of
A I CO		To Be	25. Was case referre o medical examiner? 1 Yes 3 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hospital: 1 1 1 1 1 1 1 1 1 1		ne) lence 6 □Other (Specify)
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5	itel or Atten iral Director: lled in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Tow	
	To the Hospitel or Attending Fri within 24 hours after death. To the Funeral Director. After th completely filled in by the funeral	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. 29b. Signature and the of certifier 29c. License number	red at the time, o	cause(s) and manner as stated. Jate and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
			30. Name and address of pron who completed fideath (Item 23a) (Type, Print) 3509 Ea	x ster	08.24.06 NAVPLUE ESLI
	Sta Regist		SEP 1 4 2006 SEP 1		

State of Maryland / Department of Health and Mental Hygiens, 29188 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Charles Nelson Bebee 09/06/2006 10:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Laurel Prince George's 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) O3/10/1923 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1(XM 2□ F Director 527-05-8189 Michigan Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow the Medical Exercitor must be notified at 1√Yes 2□No Director MD Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 9905 Boise Road or Items 23a 20708 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ No ð 3 ₩idowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Dept. of Agriculture US Government other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other peny injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Bebee Irene Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Bebee SON 5794 Paradise Ave., Elkridge, MD 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Cemetery 09/08/2006 Falls Church, VA 22. Name and Address of Facility
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20. Name and Address of Facility 21. Signature of Funeral Service Licensee M01378 7250 Washington Blvd., Elkridge, MD 21075 Part 1, Enter the disease, or comshock, or heart failure. List on complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cerebral Thrombosis **Physician** Minutes /Medical Due to (or as a consequence of): Examiner Metastatic Cancer Months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner physicien and is the burial-transit The law requires that the death certificate be executed Broncho enic Carcinoma Years that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ pe Chronic Obstructive Lung Disease 3 Probably 4 Unknown Yes 2□No page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform this certificate 1 ☐ Yes 2 ☐ No 2X) No To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death / Check only one Hospital: 1 Xnpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 28a. Date of fnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 2 Accident 5 Pending investigation 1 Tes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) September 7, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 William A. Warren, 321 Prince George Street, Tourd, ND 20707 31. Date filed (Month, Day, Year) 3 Hegistrar's Signature State 4 Registrar

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

mip Lee Butch	•	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg No 2016
Physicia Medical Exami	ın/	Philip Lee Butcher 2. Date of Death Month Day September 4, 2006 2. Date of Death September 4, 2006 1530 hrs
and the same of		4a Facility Name (if not institution, give street and number) 4b City, Town, or Location of Death 4c County of Death
Funeral		Sinai Hospital Baltimore City Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or
Director		080-54-8156 12M 2 F 34 Yrs Months Days Hours Min. 12-09-1971 Foreign Country) Dela ware
Maryland 28a-f show any d at once.	Ī	10a. State 10b County 10c. City Town or Location 10d Inside City Limits 1 Yes 2 No
Fe e	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13 90 010 Princess Ame RD 21853 U.S. A
th with th ems 23a t be noti	Funeral [11 Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 2 Married 3 Married 4. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc. 14. Race - American Indian, Black, White, etc.
after deat al". or itc	by Fun	3 Widowed 4 Divorced If Yes, Give Year or Dates. 1 Yes 2 No specify: Speci
15-0036 Tited within 72 hours after Hygiene d other than "natural".		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) 17b. Decedent's Education (Give kind of work done during most of working life DO NOT use retired)
edie eli	Completed	17 Eather's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname)
21215-0036 wild be filed within 72 hours afte Mental Hygiene marked other than "natural": c event, the Medical Examiner	Be	Phillip Thorn Ton Elizabeth Butcher
	٩	19a Informant's Name/Relationship (Type, Print) Mu that 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EU Zube HH Butcher 1411 5T. Gevry: Ave Baits Ma 21207
		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date cremation - City or Town, State Crematory or other place)
Baltimore, permit Pages I as Department of He Important: If ite		4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Ficility Lowell Funeral House
Physician	İ	23a Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Death Death Death
The second secon	<u>ان</u>	Sequentially list conditions, if any leading to immediate bull to (or as a consequence of): Due to (or as a consequence of):
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - tra	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (Specify)
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n of Ading Phone		27. Manner of Death 28a Date of Injury (Month, Day,Year) 1 Natural 5 Pending O/2/2006 11:28 pm 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred
ivision I or Attend after death Director:	ficati	2 X Accident Investigation 9/2/2000 11:20 \(\mu\)II \(\lambda\) Subject FeII from roof 28e Place of Injury - At home farm, street, factory office building, etc. 28f. Location (Street and Number or Rural Route Number. City
Div spital o rours af	Certification:	4 Homicide determined (Specify) front yard Baltimore, MD ROCKFOSE AVENUE
To the Hospital within 24 hours To the Funeral completely fille	Medical	29a Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. 2 Medical Examiner; Op the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
T Wi Z	Me	29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year)
do		O.C.M.E. September 9, 2006 30 Name and address of person who completed cause of death (Item 23a)
- CY		Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201
S Regis	tate trar	31. Date filed (Month, Day, Year) SEP 1 4 2006 Registrar's Signature

DHMH 17 Rev 1/2001 OCME 2006

			1 - For State Registrar	State of M	aryland / Dep	partment e <i>rtificate</i>				giene Reg. No 2006	29190
	Physicia	an			RFRRY	-			Month	Day Year	3. Time of Death
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	Funeral Director							ours Min.	8. Date of Birt (Month, Da) Antember	h Y, Year) 16 - 1921 0	thplace (State or Foreign ountry) hio
			Usual Residence of Decedent	XX O					Сроспост	10, 1521	
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	s 23a	December Name (Pints Associated) prime review as controlled and the processing of th									
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121	within lene. than	omp	Elementary/Secondary (0-12)	College (1-4or	5+)					Own Ho	те
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Baltimore,	m 0		20a. Method of Disposition	☐Bemoval from State				1			
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			shock, or heart failure. List or	omplications that cause by one cause on each I	d the death. Do not e ine.	enter the mode	of dying, su	ich as cardiac c	r respiratory ar	rest,	Approximate Interval Between Onset and Death
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	To t To t	Σ	29b. Signature and title of certifier	\ A	Ž.						
	10		30. Name and address of person wh				,000	7 703		01/15/	<i>5</i> 006
7 <u>2</u>	`		How Minn GS	65 North	Charles o	St. Suit	e 303	R Bulti	mare M	D 21304	
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			Decedent's Name (First, Middle, Last)				30411	2. Date of Death			3. Time of [
	Physicia /Medic	al		002196	Barc		L continue of D	Month	13 2 4c. County of	006	7:0	59m
	Examin	er	4a. Facility Name (If not institution, give stre Glen Meadows	et and number)		4b. City, Town, or Glen A		eatti	-	imore		
	Funeral	1	5. Social Security Number 6. Sex	-	n yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 I Hours N	Hrs. 8. Date of Birth (Month, Day)	(ear)	Country	ce (State or	Foreign
L	Director		217-24-3289 XX ^M Usual Residence of Decedent	² 76) 115.			rebruary 20	5, 1930	Marý	1 and	
	aryland ahow	_	10a. State 10b. County		Oc. City, Town or Lo	ocation				10d	I. Inside City 1 ☐ Yes	
	the Ma	ecto	Maryland Baltimore 10e. Street and Number	(Glen Arm	10f. Zip Code		10	g. Citizen of Wh	nat Country		XX
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36	d within 72 hours after death with the Maryland Jiene. r then "natural", or Items 23a or 28e-f ahow I'ne Medical Ezana na must be molified at	by Funeral Directo	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	Was Decedent Eve Armed Forces? AZYes 2 No If Yes, Give Year or Dates:	Korea	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes XX No	ispanic Origin' in, Mexican, Pi Specify:	? (Specify Yes or No- uerto Rican, etc.)		American White, etc	c.	
Maryland 21215-0036	72 hou	eted	15. Decedent's Educat (Specify only highest grade of		(Give	dent's Usual Occup	during most of		6b. Kind of Bus	iness/Indu	stry	
121	within ene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		DO NOT use retired Safety En	,		Qua	rrv		
nd 2	Hyg Hyg Sthe	ø	17. Father's Name (First, Middle, Last)		'	,	18. Mother's	Name (First, Middle, M	aiden Sumame,)		
ylaı		101	Robert Samuel Sloan 19a, Informant's Name/Relationship (Type		19h Mail	ing Address (Street		e Margaret			inde)	
Mai	od 2 state ar 127 is r trau		Elizabeth Dowling Ba		vife 1163	0 Glen Ar	m Road	Glen Arm M	aryland	2105	7	
ore,	0 0 -		20a. Method of Disposition XX Burial 2 Cremation 3 Ren	soval from State		matory or other place			Oc. Location - C			
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Ba	permit. Departn Imports any inju		Connis & Yesk	en Xes	rake			Baltimore				
			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the cause on each line.	e death. Do not en	iter the mode of dyin	g, such as car	diac or respiratory arres	st,	lr.	Approximate nterval Betwonset and D	veen
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	bed isit	niner	Sequentially list conditions, b. cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):							
6	ate be executed hysician and the burial-transit	Examine	that initiated events c. resulting in death) Last	Due to (or as a	consequence of):							
8760,	ate be hysicia the bur		d.									
Вох 6	leath certifica attending ph i for use as th	Physician/Medical	23b. Was decedent pregnant	. If yes, outcome of 1 Live birth 2		□Ectopic pregnancy	,		23d. Date Mont	of delivery		ear
П	at the dea by the at tached fo	yslci	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at tir 9□Unknown	ne of death 5	Other (specify) _					-,	
Ω.	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by	Part II. Other significant conditions contr	buting to death but	not resulting in the	underlying cause giv	en in Part I.	23e. Did toba	acco use contrib	oute to the		eath?
Il Records,		Completed						24a. Was an autopsy perform 1 ☐ Yes	ed? pr	ior to comp eath?	sy findings a pletion of ca	vailable use of
Vital	Physician: The this certificate heral director, page	o Be	25. Was case referred to medical examiner?	spital:	2 ☐ ER/Outpatie	ent 3 DOA Oth		Death (Check only one ng Home 5 Resider		r (Specify)		
of	문 는 E	H-	27. Manner of Death	28a. Date of Injury (Month, Day			v at	28d. Describe how				
Division	r Attending er death. rector: After by the funer	catio	Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			M 1 🗆	Yes 2 □ No	28f. Location (Str.	oot and Numbo	r or Rural	Pouto Numb	har
DIVI	after d after d Direct	Certification:	4 Homicide determined	28e. Place of Injury building, etc.	/ - At home, farm, s (Specify)	treet, factory, office		City or Town,	State)	O FILITAL I	HOUSE NUMBER	<i>iei</i> ,
_	To the Hospitel or Attenr within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one) Certifying Physic Medical Examine	cian: To the best of r: On the basis of e and manner state	xamination and/or i	ith occurred at the til nvestigation, in my c	me, date and p pinion, death	place, and due to the ca occurred at the time, da	use(s) and man te and place, ar	ner as stat nd due to ti	ted. he cause(s)	
	To the vithin 3	Me	29b. Signature and title of certifier	^ .		29c. Licens	e number	29	d. Date signed			
)	di		TAM	entuo	ACAN I	10 D 2/	1-78	10	9113	5/ 4	NOG IRIS	
	10		30 Name and address of person who com	pleted cause of dea	ith (Item) 23a) (Torque	SLLYNA (ROSS R	Open \$150	15ALT	mi	212	28
		ate	31. Date filed (Month, Day, Year)	32. Registrar	s Signature	1						
	Regist	rar	SFP 1 4 200	D Facial	JE B	ADBALL!						

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2 [] [] 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 16 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Long Green Center N/ABaltimore If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours XIXM 2□F 88 Yrs. Director 215-07-3549 1918 Maryland 9. Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other then "natural", or Items 23s or 28s-f show other traumatic event, the Madical Examinar must be notilized at tXXes 2 □ No Directo Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 115 E. Melrose Avenue 21212 USA a filed within 72 hours after deeth vil Hygiene.

Other then "natural", or Iteme 23: 12. Was Decedent Ever in U.S. Armed Forces? 1℃ Mes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes ŽENo Specify. Baltimore, Maryland 21215-0036 ģ X₃ Widowed 4 □ Divorced Specify: white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Home Improvement-Elementary/Secondary (0-12) College (1-4or 5+) Painter Painting 5th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be fill of Health and Mental H William E. Baseman Ida Montgomery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerry A. Baseman, Sr. 518 N. Bouldin St. Baltimore, MD 21205 Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
eny Injury or oti H3Burial 2 ☐ Cremation 3 ☐ Removal from State Moreland Memorial Pk 9/14/06 Parkville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Service Licensee 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc
3631 Falls Road Baltimore, MD 21211 Denler 23a Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 1200 **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine g physicien and as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical as the attending F IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Day Year signed by the at id be detached for 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Ulaknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an hes performed' 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? the funeral director Be 26. Place of Beath (Check only one) Hospital: Other: 1 🗌 Yes 1 🗌 Inpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A investigation 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 10 Portifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 30. Name and ad 22. Registrar's Signature 31. Date filed (Month, Day, State 2006 SEP 14 Registrar

			For State Registrar	State of Maryland		tment of F		nd Menta		ne No.201	16	29	193
	Physici		1. Decedent's Name (First, Middle,	elvin Byrd					o of Dogth		XXX	3. Time of 2:55	
	/Medic Examin		4a. Facility Name (If not institution,			4b. City, Town, o Baltir					of Death		
. 3	Funeral Director		212-34-2650	. Sex 7. Age (In yrs. last		If Under 1 Year Months Days		Hrs. 8. Dai Min. (Mo	e of Birth inth, Day, Ye 23,	1923	Coun	lace (State of etry) th Car	-
death with the Maryland	a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Balti	more Co. 10c. City, T	own or Loca						1	0d, Inside Cit	
th with th	23a or 26 ast be no	al Director	10e. Street and Number 15216 Parrish	Road		10f. Zip Code	155			Citizen of W United		,	
USO urs after deal	ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Madical Examinat must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 NYes 2 No If Yes, Give Year or Dates:		as Decedent of H Yes, specify Cub. Yes 2 No	lispanic Origin an, Mexican, F Specify:	n? (Specify Ye Puerto Rican,	s or No- etc.)		, White,	an Indian, etc. ite	
within 72 hours after	iene. Than "natur The Medical	Completed	15. Decedent's (Specify only highest : Elementary/Secondary (0-12)		(Give ki lite. Do	nt's Usual Occup ind of work done O NOT use retire Barber	during most of	f working	168	Self E		ŕ	
land 2	dental Hygiene. rked other than tic event, the Me	To Be C	17. Father's Name (First, Middle, La Albert Byrd	st)			18. Mother's Suddi	Name (First,	Middle, Mai 11ey	iden Sumame	· ·)		
מים	PE		19a. Informant's Name/Relationship Mr. Jimmy D. Byr 20a. Method of Disposition 1 ☒ Burial 2 □ Cremation 3	☐ / S□□ ☐Removal from State 20b. Place cerm	320 e of Disposi etery, crema	Address (Street B Hunt fittion (Name of atory or other plan	Road	Fallst Date	on, Ma	aryland	d 2'	1047	
Baltimor	Departmer Importent any Injury		4 Donation 5 Other (Spe 21. Signature of Funeral Service in	city) Nord Pense Michael E. Canapp	22.	mily Cem Name and Addre Ruck Tou	ss of Facility	1050 Y	ork Ro			Md. 21204	
	hysician and burial-trausit the prize trausit	dicai Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List or limited and cause (Final disease or condition resulting in death) Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequent of the consequent	ed L ce of):		-		ratory arrest,			Approximate Interval Betv Onset and D	ween
death cediffic	attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. tf yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of death 9 □ Unknown	ath 3□E	Ectopic pregnanc Other (specify)	1			23d. Date Mon			∕ear
ords, P.O	been signed by the should be detached	þ	Part II. Other significant condition	s contributing to death but not resulting	ng in the und	derlying cause giv	en in Part I.			2 No	bute to th		leath? Jnknown
The law	ate has	Completed						-	a. Was an autopsy performed Yes 2	d?/ de	eath?	psy findings a mpletion of ca 2 (1) No	available ause of
OT VITAL	r this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Tyes 2 No	Hospital: 1 Inpatient 2 ☐ ER	/Outpatient	3□ DOA Ott	0.00	f Death Checung Home 5		e 6 ⊟Othe	r <i>(Specif</i>)	y)	
	er death. rector: After th by the funeral	Certification:	27. Manny of Death 1. Viatural 5 Pending 2 Accident investiga 3 Suicide 6 Could no	(Month, Day Year)	b. Time of Injury			28d. De	escribe how	injury occurre	od		
	urs after death		4 Homicide det min	building, etc. (Specify)				Cit	y or Town, S	·			ber,
the Hos	within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	(Check only 2 Medical Ex	Physician: To the best of my knowle aminer: On the basis of examination and manner stated.	and/or inve	estigation, in my o	ppinion, death	occurred at th	ie time, date	and place, a	nd due to	the cause(s	
Ţ	¥ £ 8 V		30. Name and address of person w	COMPleted cause of death (tem 23)	7.D.	Pint).	136	5	50	ptem	ber	11,2	006
V 44	4		31. Date filed (Month, Day, Year)	M. Registrar's Signature	9		Kave	n 150 a	ievan	1, Bai	ttimi	me III	21211
****	Sta Registi		SEP 1 4 20	460	Shank	&							

			1 - For State Registrar	State of M	1arylan		artmen rtificat			and M			200	6 29	9 9
	Physic	ian	Decedent's Name (First, Middle,	•	izabe	+h		Butl	er		2. Date of De Month	Day		ir I .	e of Death
>	/Medi Examir		Gladys 4a. Facility Name (If not institution,						Location of	of Death	SEP	10	& 00 County of D		JU P M
	LAGIIII	101		EALTH CAR	-				MORE				NA		
	Funeral Director		220-24-5366	6. Sex 7. A 1 □ M 2 ▼ F	nge (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 5-6-		9. 1	Birthplace (Stat Country) MC	_
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside	e City Limits
	Man)	tor	Md. NA			Balti	more							M□Y	res 2 □ No
	or 28	Director	10e. Street and Number				10f. Zip					10g. Citiz	zen of What	Country?	
	s 23a		3413 Edmondson		. = 1	2		229					USA		
920	72 hours after death with the Maryland natural, or Items 23e or 28e-1 show lical Exaciliar routi te notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	12. Was Deceder Armed Forces d 1 Tyes 2 fi If Yes, Give Year or Dates	i? ₹No		was Deced If Yes, spec 1 ☐ Yes		spanic Origin, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	1	Black, W Specify: E		
ה ה	72 ho	eted	15. Decedent's (Specify only highest	Education		16a. Dece	dent's Usua kind of wo			of worki	na	16b. Kir	nd of Busine	ss/Industry	
1212	d within giene. rr than "	Completed	Elementary/Secondary (0-12)	College (1-4o	5+)	life.	sable	se retired)	OI WOIN	ng	N.	A		
a	at a s	To Be	17. Father's Name (First, Middle, L James	Henry		1	Neale		18. Mothe		e (First, Middle,	Maiden ;	Sumame) Carte	er	
Mar	01 00 00 00		19a. Informant's Name/Relationsh								Il Route Numbe	-			0
	1 and 1 Health em 27		Cecilia Nnadozi 20a. Method of Disposition	e	20b. P	727 Place of Dispo			eld A		e, Balt			or Town, State	
=			1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.		1 0	emetery, crei	natory or o	ther place	1				=00		
	보통문문		21. Signature of Funeral Service L		M1		nel C 2. Name an			9–14 v	-06 March B		dalk,	Md.	
ñ	Dep Con Con Con Con Con Con Con Con Con Con		> Dlandy	wan	س)	1101	E. N	orth		, Balti		, Md.	21202	
į.	Physician /Medical Examiner		23a. Part1. Enter the disease, or case to the case of	a. UROSE Due to (or a	PSIS s a consequ					cardiac c	r respiratory ai	rrest,		Approxin Interval E Onset ar	Between nd Death WEEK
,0070	safe be executed hysicien and the burial-transit	Ilcal Examiner	Squentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	CDue to (or a d	s a consequ	uence of):						,			
P.O. BOX 00	law requires that the death certific as been signed by the ettending pl 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2▼ No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal	death 3	Ectopic pr		-			2	3d. Date of o	delivery Day	Year
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ב ;	lhe ete h page	Completed									24a. Was autop perfo 1 Yes	rmed?	24b. Were prior to death		gs available if cause of
<u> </u>	certificete rector, pag	Be	25. Was case referred to medical examiner?					7 -			Check only o	ne)			
5 8	ding Physician: h. After this certific funeral director,	tlon; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accordant investiga	28a. Date of In (Month, D		ER/Outpatier 28b. Time of Injury		8c. Injury Work	r 4 □ Nui at ? 'es 2 □ N	2	ne 5 Resid			овсіfу)	
	or or Attending after death. I Director: After d in by the fune	Certification;	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place of Ir	njury - At ho etc. (Specify	ome, farm, str				1.	28f. Location (S City or Tox	Street and vn, State)	Number or	Rural Route No	umber,
	lo the Hospitel or Attending Pro within 24 hours after death. To the Funeral Director, After th completely filled in by the funeral	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the bes kaminer: On the basis and manner s	of examinat	wledge, death	occurred restigation,	at the tim in my op	e, date and inion, deat	d place, a	and due to the o	cause(s) a	and manner place, and d	as stated. ue to the cause	e(s)
	vithin 2 To the complei	Me	29b. Signature and title of certifier				290	. License	number			29d. Date	signed (Mo	nth, Day, Year,)
	0		Jyothi Puman	, MD				P199	125			SEP	10, 8	2006	
5	Y		30. Name and address of person w	ho completed cause of	death (Item	23a) (Type, HOSP 17	Print)	BAC	TIMO	RE	, MD -	- 21	229		
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 4	2006 32. Rigis	trar's Signat	ture,	hadi	,							

DHMH 17 Rev 1/2001

BUTLER, GLADYS

			1 - State Registrar	State of Maryla				, ,	0000	29195
Physician Middle Record Middle	3. Time of Death 724 AM									
	Funeral	er	5. Social Security Number 6. S	Sex 7. Age (In)		If Under 1 Year	if Under 24 Hrs.	3700	NA 9. Birth	pplace (State or Foreign
	Aarylend f ehow	or	10a. State 10b. County		•					10d. Inside City Limits X☐ Yes 2☐ No
	with the had or 286-	Part Part		intry?						
36	rs after deeth		11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	1 U.S. 13. W	/as Decedent of H Yes, specify Cuba	lispanic Origin? (Si an, Mexican, Puerto	pecify Yes or No- Dican, etc.)	14. Race - Amer Black, White	, etc.
1215-00	within 72 hou ane. then "neture ie Medical E		15. Decedent's E (Specify only highest gra Elementary/Secondary (0·12)	ducation ade completed)	(Give k	and of work done O NOT use retired	during most of world)	king	16b. Kind of Business/I Baltimore (ndustry
yland 2	ould be filed v Mental Hygie arked other i atic event, to	Be	17. Father's Name (First, Middle, Last,		enter		18. Mother's Nam	se (First, Middle, M	Maiden Sumame) Lee	
	f and 2 sho Health and Im 27 is mu		Charles Burton	Son	1200	Gleneag	le Rd., B	altimore	, Md. 2123	39
altimo			1 Dental 2 Cremation 3 Capetity 4 Donation 5 Dother (Specification)	y) [Voodlawn	Cem.	9–15	-06	Baltimore,	
8	80558		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the done cause on each line.			North Ave	nue, Bal	timore, Md.	
	/Medical Examiner		disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a cons Due to (or as a cons C. MY PET	sequence of): POSIV	n	discasi	2 		Onset and Death
Box 6	death certifi e ettending ed for use as	ysician/Med	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Yes} \) 2 \(\frac{1}{2} \subseteq \text{No} \)	1□Live birth 2□F 4□Pregnant at time o	etal death 3□					.,
	quires that an signed br	Ď	Part II. Other significant conditions o	contributing to death but not i	resulting in the un	derlying cause giv	en in Part I.			,
al Reco	The la							autops	prior to co death?	
f Vit	S S D	00	examiner?	Hospital: 1 ☐ Inpatient 2	DER/Outpatient	3□ DOA Oth	00			fy)
sion o	ending Preath. or: After the		1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year,		Wor	at c?			
Divi	oital or Attendurs after death		4 Homicide determined	building, etc. (Spe	ocify)			City or Town	, State)	
	n 24 hours and 24	edlca	(Check only 2 Medical Exam	niner: On the basis of exam	mowledge, death ination and/or inve	occurred at the tin estigation, in my o	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and manner as s ite and place, and due t	itated. o the cause(s)
0	To the Complet	Ž	29b. Signature and title of certifier	mis phys	ng Silian	29c. Licens	, ,)	7	1	4
3	•		30. Name and address of person who Brian Everle	completed cause of death (I			th floor	snite 20	o. Balt; me.	re, M/3/201
	Sta Registr	te ar	31. Date filed (Month, Day, Year) SEP 1 4	2006 32. Registrar's Sig		parte				

			1 - For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of H			000	6 29196
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	George	Darrell	Brewer		2. Date of Dea Month Sept.	th	3. Time of Death 6:55 A
	Examin Funeral	_	4a. Facility Name (If not institution, give s 924 Rosedale Ave. 5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday)	4b. City, Town, or ROSE If Under 1 Year Months Days		8. Date of Birth	4c. County of Dalti Balti Year) 9.	
	Director work		213-62-0336	53	Yrs.			Jan. 1	8,1953 M	10d. Inside City Limits
	vith the Ma or 28a-f	Director	Maryland Baltin 10e. Sireet and Number 924 Rosedale Ave.			10f. Zip Code	1237	Rosedale	0g. Citizen of Wha	
920	be filed within 72 hours after death with the Maryland stal hygiene. ad other than "natural; or Items 23s or 28s-f show event, the Modical Examical minat be indiffed at	by Funeral		2. Was Decedent E Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	0	Was Decedent of Hi I Yes, specify Cuba	spanic Origin? (S n, Mexican, Puer Specify:	specify Yes or No- to Rican, etc.)		American Indian, White, etc. White
Baltimore, Maryland 21215-0036	od within 72 ho giene. er then "natur: . tre Medicel	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5-4 1 Year	(Give life.	dent's Usual Occupa kind of work done d DO NOT use retired, chanic	uring most of wo.	rking	16b. Kind of Busin	
yland	2 should be filed and Mental Hygical I is marked other reumatic event.	To Be (17. Father's Name (First, Middle, Last) John Brewer					me (First, Middle, I stina G.	,	
, Mar	is 1 and 2 should by Health and Mer Item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type Mrs. Carol L. Brev		924	ng Address (Street a Rosedale		osedale,	Maryland	1 21237
imore	90 = 5		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R. 4 ☐ Donation 5 ☐ Other (Specify)	_	Oak Lawn	natory or other place Cemetery	9/1	3/2006		ore, Maryland
Ball	permit. Pa Departmen Important: eny injury		21. Service License	Carl		! Name and Addres Ouda-Ruck 7922 Wise	Ave. D	undalk M	arvland	21222
	Physician /Medical		23a. Part Enter the disease, or complied shock, or heart failure. List only on limmediate Cause (Final disease or condition resulling in dealth)	e cause on each line	9.	of the mode of dying	1.5	4		Approximate Interval Between Onset and Death
8760,	Examiner	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of): consequence of): consequence of):					
P.O. Box 68	The law requires that the death certificate be executed ite has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Completed by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
ords, P	w requires that been signed b should be deta	ted by PI	Part II. Other significant conditions con Soft HISSUR NEO	plas M	Posterier	1	n in Part I.	23e. Did tot		le lo the cause of death? Probably 4 Unknown
al Rec	iician: The law r certificate has be rector, page 2 sh		25 W						prior med? deat	
Division of Vital Records,	Phys r this ral di	atlon: To Be	25. Was case referred to medical examiner? 12 Yes 2 No 27. Manner of Death 12 Natural 5 Pending investigation	ospital: 1 Inpalien 28a. Dale of Injury (Month, Day	28b. Time of	28c. Injury Work	r: 4 🗆 Nursing H		e) ance 6 Other (Sow injury occurred	Specify)
Divis	Hospitel or Attending 24 hours after death. Funeral Director: Afte tely filled in by the tune	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	y - Al home, farm, str (Specify)	eet, factory, office		281. Location (St. City or Town		r Rural Route Number,
	To the Hospitel within 24 hours a To the Funeral I completely filled	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of er: On the basis of and manner state	my knowledge, death examination and/or inved.	occurred at the tim restigation, in my op	e, date and place inion, death occu	e, and due to the ca cred at the time, da	ause(s) and manne ate and place, and	r as stated. due to the cause(s)
)	To To	Σ	29b. Signature and title of certifier	W		29c. License			ed. Date signed (M	
	M		Name and address of person who co	MM, d	6 Trim	ole Hill	CTILL	thesuill.	e MD :	51083 por8'500P
	Sta Registr		31. Date filed (Month, Day, Year) SFP 1 4 20	32. Registra	rs Signature	parte			•	

	1 - For State Registrar	State of Marylar	•	ent of Health ate of Deat	th	Reg. No.	2006	2919
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last THOMAS 4a. Facility Name (If not institution, give BALTIMARE WASH)	CLINE	11	ty, Town, or Location	50		County of Death	3. Time of Deat 9/34/
Funeral Director	5. Social Security Number 6. Se. 158-30-8926	x 7. Age (In yrs. 66	last birthday) If Und Yrs. Month		der 24 Hrs. 8 F	Pate of Birth Month, Day, Year) 08/01/194	9 Birthr	place (State or For
with the Maryland or 28e-f ehow be notified at Director	Usual Residence of Decedent 10a. State 10b. County MD Anne Arr		ty, Town or Location					0d. Inside City Li 1 ☐ Yes 2
23e or 2	10e. Street and Number 235 St. James Dri	ve		Zip Code 1060			en of What Cou ted Stat	,
be filed within 72 hours after death with the Maryland hall Hygiene. Indicate than "naturel", or tieme 23e or 28e-f show event, the Medical Examiner must be notified at Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Midowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1960	-1990 lf Yes, sp	cedent of Hispanic pecify Cuban, Mexi 25 No Spec			4. Race - Americ Black, White, Specify: Whi	etc. te
D 0 1 1	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		16a. Decedent's Us (Give kind of v life. DO NOT Master C	work done during m use retired)	ty Offic	Defe	d of Business/In	dustry
d 2 should be file th and Mental Hy 7 is marked oth treumatic even	17. Father's Name (First, Middle, Last) Clarence H. Cline			An	ne Balla	antine	,	
and 2 sh alth and 127 la m or treum	19a. Informant's Name/Relationship (Ty Mary Dawn Taylor/D					on, VA 22		Code)
000====	20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State	Place of Disposition (Nemetery, crematory of nesapeake (r other place)	Inc. 20	p 14	ation · City or To	own, State Maryland
permit. Pag Department Important: I eny injury o	21. Signature of Funeral Service Licens	** MO1443				Alternative Lve Baltin		ryland 21
cate be executed which is a possible of the burial-transit the burial-transit dical Examiner	Tany, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of): OIOGENTL UENCE UP THOUGH	4000553				
The law requires that the death certificate be executed as hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit completed by Physician/Medical Examin	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	33c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3 ☐Ectopic			23	d. Date of delive	ory Day Year
w requires thet been signed b should be deta	Part II. Other significant conditions cor	ntributing to death but not res	ulting in the underlying	g cause given in Pa	rt I.	23e. Did tobacco us		/
ician: The law requir certificate has been s rector, page 2 should Be Completed	25. Was case referred to medical			00 51	1	24a. Was an autopsy performed? Yes 2 No	24b. Were auto prior to condeath? 1 \(\subseteq \text{Yes} \)	psy findings avainpletion of cause
ng Phys fler this ineral dii	examiner?	lospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 3	104	28d. I	5 Residence 6 Describe how injury		1)
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, street, factory)	ory, office	28f. L	ocation (Street and City or Town, State)	Number or Rura	l Route Number,
the Hospital thin 24 hours a the Funeral I impletely filled	29a Certifier 1 Certifying Physical Check only 2 Medical Examination	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death comma tion and/or investigation	id at the time, data on, in my opinion, d	and plane, and d leath occurred at	ue to the cause(s) a the time, date and p	nd manner as st lace, and due to	ated. the cause(s)
To the within 2 To the complet	29b. Signature and title-of-certifier	n ~		9c. License numbe			signed (Month, of 12, Z	* '
CX	30. Name and address of person who co							

			1 - For Stata Registrar	State of N	Maryland / Depa <i>Ce</i>	artment of H			ene 9. No 200	6 29198
	L		1. Decedent's Name (First, Middle, L	4		A		2. Date of Death Month		3. Time of Death
	Physici /Medio		APO LON	110 B	, CAB	RERA		Suptemb		6 8-55 AM
	Examin		4a. Facility Name (If not institution, g				Location of Death		4c. County of D	
			Ellicott City He 5. Social Security Number 6.		hab. Center Age (In yrs. last birthday)		ott City If Under 24 Hrs.	8. Date of Birth	Howa	rd Birthplace (State or Foreign
1	Funeral Director		129-36-5037	1 XM 2□F	8/1 Yrs.	Months Days	Hours Min.	Month, Day,	Year)	Country)
	p.		Usual Residence of Decedent		0-4		1 1.	му 15,	1722 1	
	shov	J.	10a. State 10b. County		10c. City, Town or Le					10d. Inside City Limits 1 ☐ Yes 2X No
	the N 28e-f	Director	Maryland Balti 10e. Street and Number	more		Balti	more	10	g. Citizen of What	
	3e or	i D	5938 Prince Geo	roe Stree	t	212	07		USA	•
	death	Funerai	11. Marital Status	12. Was Decede			ispanic Origin? (Spe in, Mexican, Puerto F	cify Yes or No-	14. Race - A	merican Indian,
980	be filed within 72 hours after death with the Maryland hal Hygiene. ed other than "neturel", or flems 23e or 28e-f show event. The Medical Evantrat must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Tes 2[If Yes, Give Year or Date:	XNο	1 X Yes 2 No		manian/	Specify:	^{(hite, etc.} B lac k
21215-0036	72 ho	Completed by	15. Decedent's (Specify only highest g		16a. Dece	dent's Usual Occupa		1 1	6b. Kind of Busine	ss/Industry
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ary	should be and Mental Is marked c	-	19a. Informant's Name/Relationship		19b. Maili	ng Address (Street a	and Number or Rural		City or Town, Stat	e, Zip Code)
	5 ₹ Z ±		Inez Shortridge/	Wife			eorge Str	-	imore, M	D 21207
Baltimore,	0 0		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3	☐Removal from Sta		osition (Name of matory or other plac			0c. Location - City	
ţim			'4 □ Donation 5 □ Other (Spec				Inc. 9/14/		Baltimo	
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Г			23a. Part1. Enter the disease, or co shock, or heart failure. List on							Approximate Interval Between Onset and Death
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	a. Athe	noscleratic as a consequence of): MC Newa	(ardio va	ascular 1	difear	<u> </u>	Onset and Death
	/Medical Examiner		1	Due to (or:	as a consequence of):	0 faile	K			
		Jer	Sequentially list conditions, if any, leading to immediate		as a consequence of):	Cocos				
	sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c						
30,	cate be executed physician and the burial-transit	i Ex	resulting in death) Last	Due to (or	as a consequence of):					
8760,	cate ohy:	dicai	•	d	w = 500					
9		/Me	IF FEMALE:	23c. If yes, outcon	ne of pregnancy				23d. Date of	delivery
D. Box	0 0	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth	2 Fetal death 3 at time of death 5	Ectopic pregnancy Other (specify)			Month	Day Year
P.0	that the ed by detacl		Part II. Other significant conditions	contributing to death	n but not resulting in the t	inderlying cause give	en in Part I.	23e. Did tob	acco use contribute	e to the cause of death?
Records,	uires n sign ld be	ed by						1 ☐ Ye.	s 2 No 3	Probably 4 Dinknown
900	e law req has beer je 2 shou	Completed						24a. Was an		autopsy findings available to completion of cause of
		Com						perform	ed? death	
/ita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospitals		04	26. Place of Death		7:510	
of Vital	Phys this ral dii	. To	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpa			4 Nursing Hor		nce 6 Other (S	(pecify)
O	th. : After	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigati	(Month, I	Day Year) Injury	Work	(? Yes 2 □ No	od. Describe no	w injury occurred	
Division	f or Attending after death. Director: After I in by the fune	Certification:	3 Suicide 6 Could not	be 28e. Place of	Injury - At home, farm, st etc. (Specify)	reet, factory, office	2	8f. Location (Str. City or Town,	eet and Number or	Rural Route Number,
Ö	itel or A irs after rel Direc led in by	Cert	4 Homede	Dustaing,	екс. (Эрвску)			City of Town,	State)	
	To the Hospitel or Al within 24 hours after of To the Funerel Direc completely filled in by	edicai	29a. Certifier (Check only one) 1 Certifying f 2 Medical Extended	hysicien: To the be miner: On the basis and manner	st of my knowledge, deat s of examination and/or in stated.	th occurred at the time exestigation, in my op-	ne, date and place, a pinion, death occurre	nd due to the ca d at the time, da	use(s) and manner te and place, and o	as stated. due to the cause(s)
	To the To the Complet	Me	29b. Signature and title of certifier	rank	of examination and/or in stated. If death (Item 23a) (Type, Item 23a) (Ty	29c. License	number	29	d. Date signed (Me	onth, Day, Year)
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	M		Rankl Sabupal	ir and	Back Ils.	Ver Meck	Road 1	Lallin	no May	lan 2/221
	Sta		31. Date filed (Month, Day, Year)	32. Reg	strar's Signature	had.				-
	Registr	ar	SEP 1 4	ZUUD	series is	C. S. S. C.				,

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AMEND TIEM#3, perPHYS. G859, 9/14/06, WS
State of Maryland / Department of Health and Mental Hygiene 0 0 6 1 - For State Registra Certificate of Death nt's Name (First, Middle 2. Date of Death 3. Time of Death 19-08 Day 2006 Physician 9:30 \mathbf{P}_{M} /Medical 4c. County of Death City, Town, or Location of Delath institution, give Examiner Himore andu bwn If Under 1 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 8. Date of Birth (Month, Day, 9. Birthplace Country) (State or Foreign Days Hours 213-36-2 🗆 F حاجا Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10d. Inside City Limits City Town oal ocation item 27 is marked other then "naturel", or Iteme 23a or 28s-f show other treumatic event, the Medical Examinar must be notified at 1 Yes 2 10 stown by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 113 10r00 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant: If item 27 is marked other then "naturel", or Iteme 23 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace 11. Marital Status American Indian Armed Forces'
1 Yes 2 |
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) foreman vyrs 17. Father's Name (First, Middle ther's Name (First, Middle, Be ပ Lepartment of Health an Important: If item 27 is n eny injury or other: town, ND 21133 1 Kandul 20a. Method of Disposition Place of Disposition (Name of Location - City or Town, State 2 Cremation 1 Burial 3 Removal from State 5 Other (Specify) 21. Signa Kandallstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart trillure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner has been signed by the attending physicien and ge 2 should be detached for use as the burial-transit & Cu that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal dea
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Day Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No Probably 4 DUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy certificete ING 1 ☐ Yes or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 2 Other: 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 Yes 2 No 2 Accident Director 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours effer of To the Funerel Direct completely filled in by 4 Homicide To the Hospitel 1 Contitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 9 completed cause of death (Item 23a) (Type 10 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 12, 2006 14:27 Sept. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) Feb. 27,1958 If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 X F Yrs. 212-76-2652 47 MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Menta! Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 No **Funeral Director** Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 923 Blakistone Road 21060 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cleveland Shoemaker, Jr. ပ္ Vivian May Wilder 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a If item 27 Is or other tree Mr. Donald Eugene Campbell 923 Blakistone Road Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Sept. 16, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. * 4 □ Donation Ø □ Other (Specify) Cedar Hill Cem. 2006 Brooklyn Park, MD 21. Signature of Funeral Service Ligenses 22. Name and Address of Facility Singleton Funeral Home, P.A. 1 Second Avenue SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the dilath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Intracerebral Hemorrhage **Physician** 30 oninutes /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical as the IF FEMALE: 950 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy ŏ in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 3 Probably 1 🗌 Yes 2 🗆 No 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? res 2 No certificate 1 Yes To the Hospital or Attanding Physician: director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 2 No 1 Inpatient funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation hours after death 2 Accident To the Funaral Director: completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funaral I Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NESSIC Sharan 31. Date filed (Month, Day, Year) 32 egistrar's Signature State Registrar

			For State Registrar		State o	f Maryla		artment of H tificate of	lealth and I Death	Mental Hy	giene	200	5 29201
			Decedent's Name (F)	irst, Middle, Lasi	')					2. Date of De	ath		3. Time of Death
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	Examin		4a. Facility Name (If not	_				4b. City, Town, o	r Location of Death	1	4c. C	County of Dea	th
			Collington		pal Li				Bowie		Pr	ince G	eorges
	Funeral Director		5. Social Security Numb 579-60-540	1 4	M 2	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di 10/09	ay, Year)	9. Bir Co DC	thplace (State or Foreign buntry)
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	the h	rect	10e. Street and Number		ocorge.	, BC		10f. Zip Code			10g Citize	en of What Co	
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ē,	s 1 ar f Hee item 3	1 1	20a. Method of Disposit			1	Place of Dispo	sition (Name of natory or other pla		Date		ation - City or	Town, State
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Ba	permit. Pege Department of Important: If eny injury or once.		21. Signature of Funera	al Service Licens	2	PU0135	& F	Name and Addre Rapp Fune: 33 Gist 1	ral & Crem	ation Se er Sprin			20910-
			23a. Part1. Enter the d shock, or heart la	isease, or comp	lications that one cause on o	aused the dea	ath. Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
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	/Medical Examiner		resulting in death)		w	(or as a conse							
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>	nysicia nis ceri direct	ToE	examiner? 1 ☐ Yes 2 No		Hospital: 1 🗍	Inpatient 2[☐ ER/Outpatien	t 3 DOA Ott		ome 5 🗆 Resi		☐Other (Spe	cify)
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Division of Vital Records,	effer death effer death Director: d in by the f	Certification:	4 Homicide	determined	286. Place	of Injury - At ing, etc. (Spec	nome, larm, str	eet, factory, office		City or To		Number or Hi	ural Route Number,
	To the Hospitel or Attending Physician: within 44 hours felar death To the Funeral Director. Aller this certified completely filled in by the funeral director. I	edicai C	29a. Certifier 1 (Check only one)	Certifying Phy Medical Exam	iner: On the b	best of my kr asis of examir ner stated.	nowledge, death nation and/or inv	occurred at the tild vestigation, in my o	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) a date and p	nd manner as place, and due	s stated. to the cause(s)
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	, 7X1		30. Name and address	of person who c	ompleted cau	se of death (Ite	em 23a) (Type,	Print)					
	V		William Dub	oyce, M					6 Bowie,	MD 207	16		
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Physician /Medical Examiner
Funeral

SEPTEMBER 8, 2006 8:45 p.m.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

WILLIAM DANIEL

	•	1 - Stele Registrar			Cei	rtificate of l	Death		R	eg. No.	UUb	29202
		1. Decedent's Name (First, Middle	a, Last)					2.	Date of Deat		Vaar	3. Time of Death
Physicia		William	E.			Danie	l Jr.		Month 09	08 ^{Day}	2006	8:45p.M
/Medic Examin		4a. Facility Name (If not institution Stella Maris)		4b. City, Town, or TOW		Death			nty of Death altim	ore
Funeral Director		5. Social Security Number 346-50-5776	6. Sex 7. A	ge (In yrs. last b	oirthday) Yrs.	If Under 1 Year Months Days	If Under 2	4 Hrs. 8. Min.	Date of Birth (Month, Day, 2 04	1 ^{Year)} 55	9. Birthpl Coun	lace (State or Foreign try)
		Usual Residence of Decedent		-		1						
ytand		10a. State 10b. County		10c. City, To	wn or Lo	ocation					10	0d. Inside City Limits
Mar	to	MD N	Д	Bal	tin	ore						1 X Yes 2 □ No
r 28g	irec	10e. Street and Number				10f. Zip Code			1	0g. Citizen	of What Coun	try?
h with	D B	3313 Liberty	Height Av	e NFLI		2	1215				U.S.A	•
deat	Funeral Director	11. Marital Status	12. Was Decedent		13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origi	in? (Specify	Yes or No-		Race - America	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: if Item 27 is marked other than "naturel", or Iteme 23s or 28s-f show eny injury or other traumatic event, Ite Medical Examinat must be notified at once.	by	Never Married 2 Marri 3 Widowed 4 Divorced	ied 1 ☐ Yes 2 🔀	No		1 ☐ Yes 2 No	Specify:		211, 010.7	Spe		ack
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Deparimpo impo eny ir		1 Donald	C. June	t	Mā 43	arch F/H	West sh Av	t ve, E	Baltin	nore,	Md	21215
		23a. Pa 71. Enter the disease, or shock, or heart failure. List	complications that gause only one cause on each	d the death. Do	not ent	ter the mode of dyin	g, such as c	ardiac or re	spiratory arre	est,		Approximate Interval Between
Physician		Immediate Cause (Final issee a or condition risk ting in death)	CONGEST								L	Onset and Death
/Medical		rasy ting in death)		s a consequence								
Examiner		Sequentially list conditions,	b									
D #	Examiner	if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	s a consequence	e of):							
and tran	cam	that initiated events resulting in death) Last	C. Due to for a	s a consequence	o of):					_	_	
cien curial	E E		Due to (or as	a consequence	a 01).							
certificate be executed iding physicien and ise as the burial-transit	edical		d									
ding	/Me	IF FEMALE:	23c. If yes, outcome	e of pregnancy						224	Date of delive	
	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal dea at time of death		Ectopic pregnancy Other (specify)						Day Year
at the de by the e	Physic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	at time or doas.				=\v-===				
₽ ₽ ₽	F.	Part II. Other significant condition	ons contributing to death	but not resulting	in the u	nderlying cause give	en in Part I.		23e. Did tol	bacco use c	ontribute to th	e cause of death?
uires sign Id be	d by								1 □ Y	es 2 No	3 ☐ Prob	ably 4X Unknown
w requir been si should I	Completed								24a. Was a	n 24	b. Were autor	psy findings available
The larete has	Ĕ		·					_	autops perforr	ned?	prior to cor death?	npletion of cause of
	ပို	25. Was case referred to medica	1				26 Place	of Dooth /C	1 ☐ Yes : heck only on	No No	1 🗆 Yes	2 No
yelclan is certifi director	0	examiner? 1 ☐ Yes 2 🕱 No	Hospital: 1 ☐ Inpat	ient 2 🗆 ER/0	Dutnatier	nt 3 DOA Oth	00				Other (Specify	HOSPICE
F E	-	27. Manner of Death	28a, Date of Ini	ury 28b	. Time o				. Describe ho			HOSFICE
nding ith.	atio	1X Natural 5 ☐ Pendir 2 ☐ Accident investi		ay rear)	Injury		c? Yes 2∐N	10				
Atte	Iffici	3 Suicide 6 Could 4 Homicide determ	pined 288. Place of II	njury - At home,	farm, st	reet, factory, office		28f.	Location (SI City or Town		mber or Rura	l Route Number,
alor s afte ni Dir	Certification:	4 I Homeda	bullaing, e	etc. (Specify)					City of Your	ii, Olaloj		
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fun	Medical (ng Physician: To the bes Examiner: On the basis and manner s	of examination a								
o the	Me	29b. Signature and title of certifie				29c. Licens	e number		2	9d. Date sig	ned (Month,	Day, Year)
F 3 F 8			10			D	127	20		91	11/06	
		30. Name and address of person	who completed cause of	death (Item 23)	(Tyne	Print)	1	-1		-//	,, 00	
1		DR. TARIO MAI		DULANEY			TTMON	TIM .	MD 210	93		
10	ate	31. Date filed (Month, Day, Year,	- 40	trar's Signature	4 431	MIL KU	TILION	10119	.u 210	,,		

State

Registrar

SEP 1 4 2006

			For State Registrar	State of Ma	-	partmen e <i>rtificate</i>			nd Mer		giene leg. No.	200	5 29	203
	Dhysisi		Decedent's Name (First, Middle, La	st)					2.	Date of Dea Month		Year	3. Time of	
	Physicia /Medic	al		Ellis-Sim	ims	4h Cih	Tour or	Location of		eplen		12, 2006 county of Death	14:15	- рм
4	Examin	er	4a. Facifity Name (If not institution, given Sina; Hospital		14 More	1	ce (+	JW10			40. 0	Oblity of Death		
	Funeral Director		5. Social Security Number 6. S 220-74-4852		(In yrs. last birthda 38 Yrs.	-	1 Year Days	If Under 2 Hours	24 Hrs. 8. Min. 2	Date of Birth (Month, Day 25	1968	Cou	place (State o intry) V D	r Foreign
	land bw		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location							10d. Inside Ci	ty Limits
	a-f eh	ctor	MD Baltim	ore	Wa	dsto	cK						1 🗀 Yes	2 X No
	with the	Dire	10e. Street and Number			10f. Zip	_	, b			10g. Citize	en of What Cou	intry?	
	ne 234	eral	11. Marital Status	12. Was Decedent E	ever in U.S. 1	3. Was Deced	211(dent of H		jin? (Specif	y Yes or No-	14	A. Race - Amer		
36	be filed within 72 hours after deeth with the Maryland nat Hygiene. de other than "natural", or iteme 23a or 28a-f ehow event, the Madical Examiner must be notified at	Completed by Funeral Director	1 Never Married 2 Married	Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	0	If Yes, spec	- 4	in, Mexican, Specify:	, Puerto Hic	an, etc.)		Black, White		
21215-0036	tural'	ed b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's E	ducation	16a. De	cedent's Usua	al Occup	ation				d of Business/I		
215	c * at	nplet	(Specify only highest gr Elementary/Secondary (0·12)	ade completed) College (1-4or 5	life	ve kind of wor a. DO NOT us	se retired	1)	of working			urtmun+	9	
	filed with Hygiene. Ither ther		17. Father's Name (First, Middle, Las.	Lyears	Ψ,	rogram	An	18. Mother	r's Name (F	irst, Middle,		mane)	ervice	5
land	should be filed within to Mental Hygiene. marked other than imatic event, the Mental to Mental to Mental to Mental to Mental to Mental to Mental to Mental to Mental to Mental to Mental to Mental to Mental to Mental to Men	To Be	Edward Ellis	,						Gold		ŕ		
Maryland	d 2 strant		19a. Informant's Name/Relationship Darry 1 Simms / H	(Type, Print)	19b. Ma			and Numbe	r or Rural R	loute Numbe	r, City or	Town, State, Z. 21163	_	
J.	es 1 an of Heel fitem 2 r other		20a. Method of Disposition	Themselfon State	20b. Place of Dis	sposition (Namerematory or o	ne of other place	(0)	Date	i Curqui	20c. Loca	ation - City or 1	own, State	
Baltimore,	Page ment cant; if		1 Burial 2 Cremation 3 [4 Donation 5 Other (Speci		Greenr	nount			7-14-	-2006	Balt	imore,	MD	
Balt	1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn C. Greene Junioral Random Random Rand									dallota	wn r	mo al	183	
ı			23a. Part1. Enter the disease, or conshock, or heart ailure. List only	nplications that caused one cause on each fin			de of dyin	ig, such as	cardiac or re	espiratory an	rest,		Approximat Interval Bet Onset and	ween
1	Physician /Medical		fmmediate Cause (Final disease or condition resulting in death)	a. Septio	SKO	CK							IWK	_
ı	Examiner		Sequentially list conditions	Meta	s tati	c 6	as:	tric	Ca	rdi	1011	na	140.	
0	pe tist	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequence of):									
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68760,	ate be hysicie the bu	lical		d										
9 X	leath certifical attending phy I for use as th	/Med	IF FEMALE:	23c. If yes, outcome	of pregnancy						23	3d. Date of deli	verv	
P.O. Box	law requires thet the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown		3 □Ectopic po 5 □ Other (sp		<u>'</u>				Month	-	Year
	luires thet n signed b ıld be deta	ام	Part II. Other significant conditions	contributing to death be	ut not resulting in the	e underlying o	ause giv	en in Part I.			obaccous (es 2 🗆	e contribute to		Juknown
Records,	taw requir nas been si e 2 should	Completed								24a. Was autop		24b. Were au prior to death?	topsy findings ompletion of a	
al H	n: The ficete har, page	e Cor	25. Was case referred to medical					OC Place	of Dooth //	1□ Yes	2 No	1 Tes	2 No	
of Vital	ysicia is certi directo	To Be	examiner?	Hospitaf: 1 XInpatie	nt 2 ER/Outpa	tient 3 DC	Oth	000		Check only o		Other (Spec	ufy)	
n o	ing Ph Viter th uneral		27. Manner of Death 1 Natural 5 Pending	28a. Date of fnjul (Month, Da)	y 28b. Time Year) Injur		28c. Injur Wor			d. Describe h	now injury	occurred		
Division	Attending in death.	flcat	2 Accident investigation 3 Suicide 6 Could not determine	be 28e. Place of fnid	rry - At home, farm,	M street, factor		Yes 2□I	28			Number or Ru	ral Route Num	nber,
Ö	s after al Dire	Cert	4 Homicide determine	building, etc	c. (Specify)					City or Tou	vn, State)			
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical Certification:		Physician: To the best of aminer: On the basis of and manner sta	examination and/o									s)
	To the To the comp	M	29b. Signature and title of certifier	Taleson 1	4BBS		c. Licens	se number	00			signed (Month		200
	5		30. Name and address of person who		eath (Item 23a) (Ty S1NA 11	pe, Print)			BALTI	MORE				
		ate	31. Date filed (Month, Day, Year)	32 Registr		peels								
	Regist	Idi	SEP 1 4 20	06	or will be to the	AND AND AND AND AND AND AND AND AND AND								

06-06902 Sheryl Frias Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

neryi i nas		1- For State Certificate of Death Registrar		eg. No. 20	06 2920
Physiciar	1/	1. Decedent's Name (First, Middle,Last)	2. Date of Dea Month	th Day Year er 12, 2006	3. Time of Death 2245 hrs
ledical Examin		Shery1 Anne Frias 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea		er 12, 2006 4c. County of Death	
لين		St. Agnes Hospital Baltimore		N/A	
Funeral Director		$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	in	Foreig	thplace (State or on nuntry) NC
>:		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d, Inside City Limits
ow any	- 1	MD Baltimore Catonsville			1 Yes 2 No
Aaryland 28a-f show 1 at once.	황	10e. Street and Number 10f. Zip Code	1	l0g. Citizen of What Cou	
th the Maryland 23a or 28a-f sho	Director	617 Southmont Rd 21228		USA	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shreatic event, the Medical Examiner must be notified at once	uneral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (14. Never Married 2 37 Married Armed Forces? 15. Was Decedent of Hispanic Origin? (16. Keyer Married 2 17 Married Armed Forces)			ican Indian, Black,
fter de	ᄔᅵ	3 Widowed 4 Divorced If Yes 2 X No 1 Yes 2 X No specify:		Specify: Whi	te
ours a	ğ b	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re-		16b. Kind of Business/	
136 thin 72 h ne. than "n	Complete	Elementary/Secondary (0-12) College (1-4 or 5+) 4 Office Assistant		Baltimore Dept of Re	
5-00; led with Hygiene other ti	틹	17. Father's Name (First, Middle, Last) 4 Office Assistant 18. Mother's Name	me (First, Middle,	Maiden Surname)	e a rains
21215-0036 buld be filed within 72 hours after Mental Hygiene. marked other than "natural", cevent, the Medical Examiner.	8	Lester Hofler Kathlee	en Perry		
ID 21 should and Mee 77 is man	ှု	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Street and Number of			
Malth alth	-	Bron R. Frias/Husband 617 Southmont Rd Cat 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date Date	e, MD ZIZZ8	
Baltimore, M Permit. Pages I and 2 Department of Health Important: If item 2	П	1 Burial 2 VCremation 3 Removal from State crematory or other place)	/16/06	Dalla de cons	MD
e fa ne p	H	4 Donation 5 Other Specify: Metro Crematory, Inc. 9, 21. Signature of Funeral Service Licensee C. Todd Dring 22. Name and Address of Facility MacNabb Funeral I	/16/06	Baltimore	, MD
Balt permit. Depart Impor injury		C. Todd Dring MacNabb Funeral I	Home, P.	A. illo MD 21	228
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	c or respiratory ar	rest, shock, or heart	proximate Interval Between Onset and
/Medical Examiner	ı	Immediate Cause (Final disease a. Arteriosclerotic Cardiovascular Disease			Death
2		b			
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated			
uted nd ransit		events resulting in death) Last Due to (or as a consequence of): d.			
760, icate be executed g physician and the burial - transit	Medical	UNPENDED AMENDED			
760 ficate t		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic preg-	nancy	23d. Date of delive Month	ry Day Year
P.O. Box 687 that the death certific ned by the attending I detached for use as ti	Physician/	past 12 months? 1			
, Bo the dea	Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did	tobacco use contribute to	the cause of death?
P.O res that	ক্র		1 Y	es 2 No 3 Pro	obably 4 🗹 Unknown
ords, F aw requires nas been sign	Completed		24a. Was		utopsy findings available completion of cause of
e law te has ge 2 sł	gm		perf	ormed? death?	es 2 No
tal Recian: The certificate	BeC	25. Was case referred to medical 26. Place of Death (Cher	ck only one)		
Vita hysici		1 V Yes 2 No inpatient 2 V ER/Outpatient 3 DOA 4 No.	rsing Home 5	Residence 6 Other	er:
n of ding Pl h. : After			Zod. Describe	how injury occurred	
isio Atter er deat rector by the	icat	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.			ural Route Number, City
Division of Vital Rec pital or Attending Physician: The ours after death. reral Director: After this certificate filled in by the funeral director, page	Certification:	Suicide 6 Could not be determined (Specify)	or Town,	State)	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical (and due to the cau ed at the time, date	use(s) and manner as sta e and place, and due to t	rted. he cause(s)
To Cor	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (M	onth, Day, Year)
A		Thereday M. King The Man O.C.M.E.		September 13,	2006
(0)		30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltime	ore MD 2120)1	
<u> </u>		31 Date filed (Month Day Year) 32 Registrar's Signature	OIE, WID 2120		
Sta Regist	ate rar	APPEN A TRUE TO A STATE AND A			

			For State	State of Marylan		epartment of H Certificate of L		-	•	2006	20205
			Ragistrar 1. Decedent's Name (First, Middle, Last)		Jertinicate of L	Jealii	2. Date of De	Reg. No.	2000	3. Time of Death
	Physici /Media		CHARLES A.		JR.			Month	Day	2006	4-15A M
	Examir	er	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c.	County of Death	nore
	Funeral Director		5. Social Security Number 6. Se 213369771	7. Age (In yrs.)	last birth Y	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bit 6 / 20 /	11.939	9. Births	place (State or Foreign
_	D.		Usual Residence of Decedent	140-00	-						
	n the Maryland r 28a-f ehow	tor	MD BALTIM			or Location EBURG					1 ☐ Yes 2 No
	death with the me 23e or 28e r must be noti	Jrec	10e. Street and Number			10f. Zip Code			10g. Citi	zen of What Cour	ntry?
	ath w	rai	5316 1/2 HAMIL			212				USA	
~ ~ ~ 2.0036	within 72 hours after de ene. then "neturel", or items the Medical Exeminer m	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	S.	13. Was Decedent of Hi ff Yes, specify Cuba 1 Tes XXNo	spanic Origin? (Spanic Origin?) n, Mexican, Puerto Specify:	ecfy Yes or No Rican, etc.)	0-	14. Race - Americ Black, White, Specify:	
2.0	72 h	etec	15. Decedent's Edu (Specify only highest grad	ucation fe completed)	16a. [Decedent's Usuaf Occupa Give kind of work done d life. DO NOT use retired	ition luring most of worki	ing	16b. Ki	nd of Business/In	dustry
2121	d within giene. or then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 2		MECHANIC			CON	STRUCT	ION EQUIP.
	al Hygi d other	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Name				
Cho yland	should to nd Ment marked umatic e	2	CHARLES A. FRE					HY C.			
Mar	12 sh h and 7 ie m traum	1	19a. Informant's Name/Relationship (T)		1	Mailing Address (Street a					
6 6	1 and Health tem 27 other t		DAVID F. FREUN 20a. Method of Disposition	20b. P	lace of [939 SUE CF Disposition (Name of		ESSE:		D 2122' cation - City or To	
Frenh Baltimore	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other then any injury or other traumatic event, Ite Mange.		1 ☐ Urial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify)	removal from State 🗸 🥆 1		crematory or other place NS OF FAIT		/06	BALT	IMORE,	MD
P. Balt	permit. Departr Imports any inj		21. Signature of Fucural Service Licens) -2		22. Name and Addres	s of Facility CV SACO AVE			ALE FUI	NERAL HOME MD 21237
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	fications that caused the death	n. Do no					THORE	Approximate Intervat Between
	Physician		Immediate Cause (Final disease or condition	cardiopu	Imo	nory Al	rest				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):					
		er	Sequentially list conditions if any, leading to immediate	Due to (or as a consequ	h 0 uence of	CK					
19.	uted d ansit	min	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Left Low	PA	Fxtram	144 GX	of er			
0,0	cate be executed physicien and the burial-transit	dicai Examiner	resulting in death) Last	Due to (or as a consequ	uence of):					
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			IF FEMALE:	23c. If yes, outcome of pregna	ncv		707			12d Date of dall-	
P.O. Box	The law requires that the death certificate has been signed by the ettending to bage 2 should be detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)				23d. Date of delive Month	Day Year
	s that ned b e deta	y Pt	Part II. Other significant conditions co	ntributing to death but not resu	ulting in t	he underlying cause give	n in Part I.	23e. Did 1	tobacco u	se contribute to the	ne cause of death?
rds	w requires that been signed to should be deta							1 🗆	Yes 2[□No 3 □ Prob	ably 4 Unknown
o co	a law re has be e 2 sho	Completed						24a. Was	psy	24b. Were auto	psy findings available mptetion of cause of
<u> </u>								1 Tes	ormed? 2∕☐ No	death? 1 ☐ Yes	2□ No
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of	ding Phys h. After this funeral di	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Tir	me of 28c. Injury	4 Nursing Ho	ne 5 ☐ Hesi 28d. Describe		☐Other (Specify occurred	y)
ion	Attending in death.	atio	Natural 5 Pending 2 Accident investigation	(Month, Day Year)	înf		? ⁄es 2 □ No				
Division of Vital Records,	after de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Pface of Injury - At he building, etc. (Specify	me, farn	n, street, factory, office		28f. Location (City or To	Street and wn, State,	d Number or Rura	l Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my knowinar: On the basis of examinat and manner stated.	wledge, tion and/	death occurred at the tim for investigation, in my op	e, date and place, a pinion, death occurr	and due to the ed at the time,	cause(s) date and	and manner as s place, and due to	tated. o the cause(s)
	To the Within 2 To the comple	Me	29b. Signature and title of certifier	1 Nax		29c. License			,	e signed (Month,	
			30. Name and address of person who co	ompleted cause of death (Item	23a) /T	vne Print	00000		7/	11/66	
	Ve		Dr. Joseph Herch	ellooth 900	o Fir	ype, Print)	ware DI	ive 1	30-11	-imorp.	MD 2/237
	Sta		31. Date filed (Month, Day, Year)	32. Redistrar's Signa	ture	Broske	W 1	, - 6			1 19 4 1 1 1
	Registr	ar	SEP 1 4	2000	F.5"	No.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2006 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** PM 2:50 09 09 2006 Ames Aherty /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE Baltimore OAK Rest If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. May 22, 1923 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1√2 M 2 □ F 83 219-18-7205 Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f ehow other traumatic event, the Medical Examinar must be notified at MD Baltimore 1 Tyes 2 No Baltimore Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Iteme 23a or 21234 U.S.A. 8820 Walther Blvd. death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1Xi Yes 2 □ No 148--149 if Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2√ No Specify: White þ 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Warehouse Worker McCarthy-Hicks, Inc. permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg Important: if Item 271s marked other eny injury or other traumers. 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Annie McDonald John Flaherty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 21234 Mary Horner-niece 3021 Summit Ave., Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 9/15/06 New Cathedral Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** metastatic Brain /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, * any, leading to him ediaticause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to jor as a consequence of Physician/Medical Examiner Due to (or as a consequence of) use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ò Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 140 24a. Was an autopsy performed? Yes 2 No 1 TYes 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 10 1 Inpatient 2 ER/Outpatient Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No hours after death. 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

Anna

DHMH 17 Rev 1/2001

M.D.

walther

\$2. Registrar's Signature

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Bou le sage

Parkville

September 11, 2006

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2006

Monius

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8800

			1 - For State Registrar	State	of Maryland /		artment of H		nd Me			06	29207
İ	Physici /Medic		Decedent's Name (First, Middle, La	,	aphinia A	Fir	nk			Date of Deatl Month	h	Year	3. Time of Death 1:19 P
	Examin		4a. Facility Name (If not institution, given		imber)		4b. City, Town, or	Location of		осресни	4c. County of		1.19 F
	Funeral Director		3205 Gentian La 5. Social Security Number 223-26-2909 6. 9		7. Age (In yrs. last	<i>birthday)</i> Yrs.	If Under 1 Year Months Days	Mid If Under 24 Hours	4 Hrs. 8 Min.	River Date of Birth (Month, Day, March 1	Year)	9. Birthp Coun	ore Co. place (State or Foreign of try)
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation						0d. Inside City Limits
	death with the Maryland rms 23a or 28a-f ehow Lithual be notified at	ctor	Maryland Balt:	more					M	iddle R	iver		1 ☐ Yes 2 XNo
	a or 28	Director	10e. Street and Number 3205 Gentian La	ane			10f. Zip Code	212	220		g. Citizen of W		
õ	be filed within 72 hours after death with the Marylan ital Hygiene. Adother than "natural", or flems 23a or 28a-f ehow event, the Medical Examiner must be notified at	y Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married	Armed F	2 🛛 No		Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2₺ No	spanic Origin n, Mexican, Specify:	in? (Specif Puerto Ric	v Yes or No-			an Indian,
Š	tural,	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's E	Year or E	Dates:		dent's Usual Occupa			1	16b. Kind of Bus		White
9500-61212	d within 72 jiene. r then "nat	Completed	(Specify only highest gri Elementary/Secondary (0-12) 10 Years	de completed)	1-4or 5+)	(Give life.	kind of work done d DO NOT use retired) emaker	urina most c	of working		Own H		lustry
land	ntal Hygie ed other event, II	Be	17. Father's Name (First, Middle, Last								faiden Surname)	
Maryi	2 should be and Mental is marked or	ဥ	Oran M. Phillip 19a. Informant's Name/Relationship (Husband 1	9b. Mailir	ig Address (Street a			e Mull Route Number,		itate, Zip	Code)
e, M	カチトラ		Mr. Charles H. Fi	nk, Sr.		3205	Gentian		Midd	dle Riv	er, MD	212	20
	ages 1 int of H t: If Ite y or ot		20a. Method of Disposition 12 Burial 2 □ Cremation 3 □		State ceme	tery, crer	sition (Name of natory or other place em. Gdns.		Date /2006	- 11	Oc. Location - C	•	wn, State aryland
gaith	permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other ance.		4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice		7 00	-	Name and Address Duda-Ruck	1					-
	dozed		23a Part. Enter the disease, or com	plications that	caused the death. D		7922 Wise	Ave.	Dur	ndalk,	Marylan		1222 Approximate
	Physician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	FC HA	6	15,A						Interval Between Onset and Death
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	acuted ind transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c									
0/00,	cate be executed physicien and the burial-transit	dical Ex	Tossiling in dealin, East	d	(or as a consequenc	e of):					, <u>,</u>		
O. BOX 0	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burrat-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live t	tcome of pregnancy pirth 2 Fetal dea nant at time of death own		Ectopic pregnancy Other (specify)				23d. Date Mont		ry Day Year
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ם שבנים	To the Hospital or Attending Physician: The law requir within 24 hours efter death. To the Funersi Director: Alter this certificate has been si completely filled in by the funeral director, page 2 should la	Completed								24a. Was an autopsy perform 1 ☐ Yes 2	ed? pri	or to con ath?	osy findings available inpletion of cause of
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Physician: r this certifica ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:			Othor	-		check only on			
	ding Phy h. Alter this funeral d	tion: To	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date (Mon	Inpatient 2 ER/O of Injury 28b th, Day Year)	. Time of Injury	28c. Injury Works	4 🗀 Nursi	28d		rce 6 □Other)
DIVISION	To the Hospital or Attending within 24 hours effer death. To the Funeral Director: Attended to the funeral Director with the fune completely filled in by the funeral Director with the funeral director	Certification:	2 Accident Investigation 3 Suicide 6 Could not b determined	28e. Place	o of Injury - At home, ing, etc. (Specify)	farm, str				Location (Stre City or Town,	et and Number State)	or Rural	Route Number,
	Ne Hospit	Medical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	niner: On the b	best of my knowled asis of examination a ner stated.	ge, death and/or inv	occurred at the time estigation, in my opi	, date and p nion, death	place, and occurred	due to the cau at the time, dat	use(s) and mann te and place, an	ner as sta d due to	ited. the cause(s)
	within To th	M	29b. Signature and little of certifier	No	ele I in	110	29c. License	number 13	<i>y</i>	296	d. Date signed (Month, E	ay, Year)
	10		30. Name and address of person who	completed caus	se of death (Item 23a	(Type, I	Print) Theer	3	cet	eune,	More	Card	21204
	Sta Registra		31. Date filed (Month, Day, Year) SEP 1 4 20	27	Registrar's Signature	Con	ules						

06-06790 Eric Fountain

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		- For State	Ce	rtificate of	Death		Reg	No OO	06 0000
Physiciar Medical Examin	1/	Decedent's Name (First, Middle,Last)					Date of Death Month	Day Yea.	2310 hrs
wedicai Examin		E1 4a Facility Name (if not institution, give street ar	ic		untain b. City, Town, or Lo	ocation of Death	September	8, 2006 4c. County of D	
		2111 Larkhall Road	a mamber)		Dundalk			Baltimore (
Funeral		5. Social Security Number 6 Sex	7. Age (In yrs	last birthday)	If Under 1 Year	If Under 24Hrs.	8. Date of Birth		Birthplace (State or preign
Director		521-17-3958 ₁ X _M ₂	_F 45	Yrs.	Months Days	Hours Min.	April :	21,1961	Country) Maryland
		Usual Residence of Decedent					-		
w au	- 1	10a. State 10b County		, Town or Locati	on	Dundal	1-		10d Inside City Limits 1 Yes 2 X No
yland I-f sho	١	Maryland Baltimore			10f Zip Code	Dundar		Citizen of What	
ith the Maryland 23a or 28a-f show any notified at once.	Director	2111 Larkhall Road					10,		,
th th		11. Marital Status 12. Was	Decedent Ever in L	J.S 13. Was	21222 Decedent of Hispa	anic Origin? (Spe	ecify Yes or No-	United S	merican Indian, Black,
eath v	uneral		ed Forces?		es, specify Cuban, N			White, e	
after d	ğ F	3 Widowed 4 Divorced If Yes, Given or Dates		1	Yes 2 X No	specify.		Specify	White
natur	<u></u>	15. Decedent's Education (Specify only highes			's Usual Occupation est of working life. D			16b Kind of Busin	ess/Industry
36 n 72 l	흶		ge (1-4 or 5+)					C1	
5-0036 led within 7 lygiene other than the Medical	Completed	12 Years 17. Father's Name (First, Middle, Last)		we	lder	B Mother's Name	(First, Middle, M		ng Industry
21215-0036 Juld be filed within 7 Marked Hygiens marked other than	Be	Roger W. Fountain					a Lee P		
2121 hould be fill and Mental I is marked utic event.		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Street a	and Number or R	ural Route Numb	er, City or Town, S	State, Zip Code)
MD and 2 sho alth and 1 is 27 is saumati		Mrs. Anna M. Fountair			Larkhall				nd 21222
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene of the filed with a special received the filed 27 is marked other than "natural", or items 23a or 28a-f she reother traumatic event, the Medical Examiner must be notified at once		20a Method of Disposition 1 Burial 2 X Cremation 3 Remo		Place of Disposi crematory or oth	tion (Name of ceme er place)	etery,	Date	20c Location - Cit	y or Town, State
Imore, MD 21215-0036 Pages I and 2 should be filted within 72 hours after death wimen of Health and Mental Hygiene Itant: If item 27 is marked other than "naturat", or items or other traumatic event, the Medical Examiner must be		4 Donation 5 Other Specify:			ervice Co		13/2006	Towson	, Maryland
Baltimore, permit Pages I at Department of Hes Important: If ite injury or other tr		21. Signature of Funeral Service Licensee		Du	ame and Address o da-Ruck F	Funeral	Home of	Dundalk	Inc.
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x 68 h certifi tending use as	<u>ē</u>	past 12 months?	Pregnant at time of d	loath	ner (Specify)				, , , ,
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Division of Vital Records, rat or Attending Physician: The law requirers after death al Director: After this certificate has been sided in by the funeral director, page 2 should be a bound to be the funeral director.	Completed						autops perforr	y prio	r to completion of cause of
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Hosp 24 ho Fune		29a Certifier 1 Certifying Physician: To the							
Division of Vital To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certif	Medical		asis of examination ner stated	and/or investigat			t the time, date a		
	Σ	29b. Signature and title of certifier	1000	~	29c. License				(Month, Day, Year)
		wat ?	all	un	O.C.M	I.C.		September 9	, ∠000
n		 Name and address of person who completed Carol Allan, MD Assistant Med 			Street, Baltimor	re. MD 21201	1		
Sta	ate.	31. Date filed (Month, Day, Year)	2. Registrar's Signa			. 5, 2 120			
Registi		SEP 1 4 2006	2. Registrar's Signa	6004					

			State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Certificate of Death Reg. No. 2006 296	209
100	Physici	an.	1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death	of Death
	/Medic	al	17/4000 SP/1 September 10, 2000 1	70/14 M
7	Examin	er	526 Robert Street Baltimore NA	
12.	Funeral Director		5. Social Security Number 3. Social Security Number 1 M 2 F 7. Age (In yrs. last birthday) 1 M 1 M 2 F 7. Age (In yrs. last birthday) 1 Months Days Hours Min. (Month, Day, Year) NOV. 10, 1954 NORTH	or Foreign AROLIN
	yland		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside 0	Dity Limits
	Ba-fs	Director	MARYLAND NIA BALTIMORE CITY 12/0	\$ 2 □ No
	with the a or 2			
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.	
215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If Item 271s marked other than "natural", or Items 23s or 28s-f show or other traumatic event, the Medical Examinations in citied at	by	3 □ Widowed 4 □ Divorced Year or Dates: 1 □ Yes 2 No Specify: Specify: Specify:	<
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ore,	of Hei		20a. Method of Disposition 1 Days 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State	
Baltimore ,	Pa mer ury		4 Donation 5 Other (Specify) METRO CREMATORY 109-18-06 SALTIMORE, MAR	YLAND
Bal	permit. Departr Imports eny inj		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 2140 N. Fulton Ave. MD 212. To seph H. Bruwn Jr. Funeral Home Baltin	nore
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line. Immediate Cause (Final	etween
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۲_	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last Due to (or as a consequence of):	
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	2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	201
施通	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	
1	Registr	aı	CED 1 / 2006 / Carlos A. A.	

		•	For State Registrar	State of Maryland	/ Department of He Certificate of D		ental Hygiene Reg. No	/ IIII h	29210
	Physicia		1. Decedent's Name (First, Middle, Las		AHAM		2. Date of Death Month Da	y Year 10, 2006	3. Time of Death 1250 PM
	/Medic Examin Funeral Director	er	4a. Facility Name (If not institution, gives 2 4	Klin Street.	4b. City. Town, or L 4b. City. Town, or L 4c. City. Town, or L	imore		County of Death O 9. Birthp Coun Sou	A lace (State or Foreign try) TH CAROLINA
the Maryland	28a-f show	rector	10a. State 10b. County MARYLAND 10e. Street and Number	10c. City,	Town or Location BAL: 10f. Zip Code	TI MORE		1 lizen of What Coun	0d. Inside City Limits 1 ØYes 2 □ No http?
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פ פ	Depa Impo any ir		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death.	Joseph H.	Brown	Tr. Funer	al Home	Approximate Interval Between Onset and Death
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Poo, To	ician and burial-tra	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs plusase of injury that initiated events resulting in death) Last	b. Due to (or as a conseque c. Due to (or as a conseque d.					
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T C	withii To th	Ň	29b. Signature and the of certifier	L. Burgent N	29c. License	1910		ate signed (Month,	
	3		30. Name and address of person who	completed cause of death (Item	23a) (Type, Print) MPRENEWINE C	ADE POA	716F 0	OU EASTER	2006 RN AVE MD 21224
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DHMH 17 Rev 1/2001

Dec: Janes Graham

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc 10 23-06 vt.
State of Maryland / Department of Health and Mental Hygiene

1 = For State Registrar Reg. No. 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** M. Gianforte Lena September 12,2006 11:25AM M Leana M.-Gianforte /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore FutureCare Cherrywood Reisterstown If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) Funeral 6. Sex Months Days Hours Min 1 ☐ M 2 🗓 F Yrs. Director 96 April 4,1910 073-10-8218 New York Usual Residence of Decedent 10c. City. Town or Location or 28a-f show 10a. State 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No Director Reisterstown MDBaltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ö item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Exemples for the figure of the figure 21136 107 Fitz Court, Apt. 102 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed with and Mental Hygien 7 is marked other th 8 Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Josephine Liberto Carmen Gianforte ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: if item 27 is rr any injury or other traum 233 Tidyman Road, Reisterstown, MD 21136 Josephine G. Stone Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐Donation 5 ☐ Other (Specify) 9/15/06 Evergreen Mem. Gardens Finksburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Reisterstown, MD 21136 Eline Funeral Home 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each fine. Approximate nterval , etween nset , d Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine requires thet the death certificate be executed use as the burial-transil that initiated events sete has been signed by the attending physician and page 2 should be detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificete has autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No il or Attending Physician: after death. I Director: After this certifice After this certifice funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Yes 2 | 1√0 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mannas of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation М 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) rson who complete cause of death (Item 23a) (Type, Print) 30. Name and adde ss o (emar en 31. Date filed (Month, Day, Year) 62. Registrar's Signature State SEP 1. 4 2006

Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 11:15 PM BERNICE AUGUST 23, 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S MEDICAL CENTER PRINCE GEORGE'S CHEVERLY If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Virginia 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 F 224-34-6779 Yrs. Director SEPT.27, 1930 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Madical Examiner must be notified at 1 AYes 2 No Director Md. Prince George's Lanham 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 20706 5811 Lawton Court United States natural, or fleme 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status ified within 72 hours after I Hygiene. other then "natural", or ite 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 Yes X No Specify: Specify: þ 3 ☐ Widowed 4 ADivorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry during most of working Elementary/Secondary (0-12) College (1-4or 5+) 12th Nurse Nursing permit. Pages 1 and 2 should be file Depertment of Heath and Mental Hy important: if liem 27 is marked othe any injury or other traumatic avents 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Susie Rudd Gee EDDIE GEE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5811 Lawton Court Lanham, Md. Darcel Moorefield Battle / Daughter 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State DINWIDDIE CEMETERY 9-9-06 4 □ Donation 5 □ Other (Specify) PETERSBURG, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WASH., D.C. 20002 CAPITOL MORTUARY 1425 MARYLAND AVE., 23a. Part1. Enter the disease or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) R. emo Chronic Physician /Medical yoular disease Due to (or as a consequence of) peripheral Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): " Examine Demen to law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): signed by the attending physicien be detached for use as the buria Division of Vital Records, P.O. Box 68760 eresis Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 2 Fetal death 3 Ectopic pregnancy Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 StUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Unknown should I Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2♣ No 24a. Was an this certificate hes autopsy performed? 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, F. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending М 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 13. Gentlying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 25a Cartille (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6 25/06 m. The 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAL DR CHEVERLY MD 20785 IA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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DHMH 17 Rev 1/2001

SEPTEMBER 10, 2006 8:35 p.m.

JUNE GETKA

ORIGINAL

06-06853

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

Frank Edward G	1	- For State	tate of Maryla		rtment of rtificate of		d Ment	al Hyg		eg. No. 2	000 00	<u>م</u> ا	
Physicia		<u>tegistrar</u> 1. Decedent's Name (First, Midd	dle,Last)						Date of Dea	th C	30 ime of beat	4	
		Frank Edward Ga	arland						Month Septembe	Day Year er 11, 2006	0756 hrs		
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Division of Vital Records, pital or Attending Physician: The law requirems after dearth rerul Director. After this certificate has been stilled in by the funeral director, page 2 should	ertification		ould not be		ionie, iann, stre	et, factory, office	building, et		or Town,		er of Rural Route Number,	Jily	
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To the Hos within 24 h To the Fuu	ical		xaminer: On the basi	est of my knowled s of examination	age, death occu and/or investiga	ation, in my opinio	n, death oc	curred at t	he time, date	and place, and d	ue to the cause(s)		
To t with To 1	Medical	29b. Signature and title of certi	and manner	stated			se number				ed (Month, Day, Year)		
	_	(DI I DA	NA	e () a	1 ~	0.0	.M.E.			September	12, 2006		
		30 Name and address of person	on who completed as	use of death (Ita	m 23a)					1			
H			on who completed ca Assistant Medica			Street, Baltin	nore, MD	21201					
	tate			kanatrar's Signa	20 1	West .		-					
Regis		2FL I	4 2000	Charles on a									

		•	For Amend #19a Perstate Registrar		aryland 9/15,	/06 JI	riment of I	Death	2. Date of De		2006	3. Time of Death		
	Physicia	ın	1. Decedent's Name (First, Middle, La Mary Hovermill	•	Month 09/10	Day		11:00 PM						
	/Medic		4a. Facility Name (If not institution, give		eath		County of Deatl							
	LAUIIIII	-	Ridgeway Manor Nu	rsing Home			Catonsvi				altimore			
	Funeral Director		5. Social Security Number 6. 1 217–40–1057		Hrs. 8. Date of Bir (Month, Da 10/15/1	h y, Year) 940	9. Birth Co	hplace (State or Foreign untry) MD						
	anyland show	_	Usual Residence of Decedent 10a. State 10b. County	cation	10d. Inside City Limits 1 ☐ Yes 3☐ No									
he Ma	the Ma	ecto	MD Howard 10e. Street and Number		ETITO	cott (10f. Zip Code			10g. Citizen of What Country?				
	th with	ai Dir	8434 Mitzy Lane				21043			USA				
036 urs after deal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show simportant: If item 27 is marked other than "natural", or items 20a or 28e-f show any highry or other treumatic svent, the Madical Examinar mastice notified at an once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Ever in U.S. No	f	Vas Decedent of f Yes, specify Cub I ☐ Yes 2 X No	an, Mexican, Pi	? (Specify Yes or No uerto Rican, etc.)	/es or No- , etc.) 14. Race - American Indian, Black, White, etc. Specify: White					
15-0	in 72 ho n "natur	Completed	15. Decedent's E (Specify only highest gi			16a. Deced (Give life. l	lent's Usual Occu kind of work done DO NOT use retire	pation during most of ed)	working	16b. Ki	ind of Business/	Industry		
212	d withing giene.	Julo:	Elementary/Secondary (0-12)	Accountant					USF&G					
Maryland 21215-0036	uld be file Jental Hy rked other illc svent,	ae	17. Father's Name (First, Middle, Las William L. Hoverm					Mary (-		400 V		
Mary	alth and to 2. Sho		19a. Informant's Name/Relationship Raymond Hovermill	(Type, Print Brot l / SON	-	8434	Mitzy La	ane, Ell		ural Route Number, City or Town, State, Zip Code) Cott City, MD 21043				
Baltimore,	of Hei		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	Removal from State			sition (Name of natory or other pla		Date		ocation - City or			
ij	tment tant: tant:	1	4 Donation 5 Other (Spec	ify)	Meado		Memorial Name and Addr		/14/2006	Ell	kridje,	MD		
Ba	Depar Impor		21. Signature of Funeral Service Ligarity	™ MC	1378	Ga 72	ary L. Ka 250 Washi	aufman I ington I	Funeral Ho Blvd., Ell	rido	at MMP, ge, MD 2	21075		
19			23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death											
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Hetartake Renal Pell Careiroma Tyears											
	cate be executêd physicien and the burial-transit	dical Examiner												
.O. Box 6	The law requires that the death certifics are has been signed by the attending ploage 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ √0 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown			23d. Date of delivery Month Day Year							
Ω.	s that the ned by a detact	by Ph	Part II. Other significant conditions		but not result	ting in the u	nderlying cause g	iven in Part I.	23e. Did	tobacco		o the cause of death?		
rds	w requires been sign should be	ed b	Atrial Ritial	_ 10	1 Yes 2 No 3 Probably 4 Denknown									
Division of Vital Records,	: The law recete has be page 2 sho	Completed	Atrial Elm	24a. Was auto perf 1 ☐ Yes	autopsy prior to completion of cause of death?									
ital		BeC	25. Was case referred to medical examiner?						Death (Check only	one)				
of V	hysic this ce al dire	ုင	1 Yes 2 → Mo	Hospitaf: 1 ☐ Inpat		R/Outpatie	IL 30 DOA		ng Home 5 ☐ Res	esidence 6 Other (Specify)				
sion (To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificd completely filled in by the funeral director.	Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could not	be -	ay Year)	Injury	M 1(□Yes 2□No						
Divis	s after de salte	Certific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	288. Place of II	njury - At hon atc. (Specify)	ne, farm, st	reet, factory, office	9	281. Location City or To			ural Route Number,		
	Hospit 24 hour Funera etely fills	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	hysician: To the bes aminer: On the basis and manners	of examination	rledge, dear on and/or in	th occurred at the evestigation, in my	time, date and p opinion, death	place, and due to the occurred at the time	cause(s date an	s) and manner and place, and during	s stated. e to the cause(s)		
	To the within To the compl	Me	29b. Signature and title of certifier					nse number		29d. Da	ate signed (Mon	th, Day, Year)		
	, 0		10000	Cemason	d45 (lane	73a) (Turn		9667		_	-11-20	06		
	(3		30. Name and address of person who Couract Succession				34508 (Oley Bren	is, Marylan	145	1061			
	St Regist	ate irar	31. Date filed (Month, Day, Year) SEP 1 4	2006 32. Regis	trar's Signati	ure	1							
DI	1MH 17 Rev 1/	2001		2006	CON J	5 19	Desta S				-			
						ORIG	NAL							

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Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

James Patrick Ha		an - For State	Stat	e of Maryla				d Menta	al Hyg	jiene				
Physicia		Registrar Certificate of Death								Reg No. 2 0 036 ime of Zeats 2				
Medical Examir	3 1/									Month Septembe	Day Year er 10, 2006	2140 hrs		
Ment.		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death										f Death		
		University of M	/laryland H	lospital			Baltimore				N/A			
Funeral		5. Social Security Num		Sex	7. Age (In yrs. I	last birthday)	If Under 1 Year Months Day		24Hrs Min.		rth(MM/DD/YYYY)	9. Birthplace (State or Foreign		
Director		088-46-9	374	X M 2 F	53	Yrs		/S Hours	IVIII I.	APR 2	2, 1953	Country) NY		
à:	Ŀ	Usual Residence of De 10a. State 10b	cedent County		10c. City	, Town or Locat	ion					10d. Inside City Limits		
I I I I I I I I I I I I I I I I I I I			N/A			timore						1 Yes 2 No		
nylane ka-f sh	뢍	10e. Street and Number			Dal	rimore	10f Zip Code			1	0g. Citizen of Wha			
ith the Maryland 23a or 28a-f show any notified at once.	Director	1432 Sout	h Hano	ver St			21230				USA			
with t	L	11. Marital Status			cedent Ever in U		s Decedent of Hi				14. Race	- American Indian, Black,		
r death wi or items	اق	1 Never Married	2 Marr	ied Armed F	2 X No		es, specify Cuba		Риело Кі	can, etc.)	White			
after	Ð.	3 Widowed		or Dates:	ar		Yes 2 X No				White			
hour	ted	15. Decedent's Educa		College (t's Usual Occupa ost of working life				16b. Kind of Bus	siness/industry		
136 bin 72 e than	əd	Elementary, 6 element	a., (0 .2,	, ,	5+	Marin	e Engin	eer			Maritin	me Shipping		
5-0036 led within 7 Hygiene Lother than	Completed	17. Father's Name (Fir	st, Middle, La	ast)					Name (F	irst, Middle,	Maiden Surname)			
2121! ould be fill Mental F marked	Be	James J.	Control of the Control							Condo				
□ gg ng gg mg	유	19a Informant's Name Kevin Han					anbury					n, State, Zip Code)		
and 2 ealth 2 iem 2)	ŀ	20a. Method of Dispos		Other	20b.		ition (Name of ce			Date II		City or Town, State		
Baltimore, germit Pages I an Department of Her Important: If ite		1 Burial 2 X	_			crematory or ot		_	9/1/	4/06	D 7			
Itim nit Pa artmer ortani	-	4 Donation 5 21. Signature of Funer			11 D	etro Cr	ematory	, Incl.	J/ 1-	+/ 00		more, MD		
Balti permit Departr Import	-	C. The		U. 1	Codd Dri	ng CL	9 Frede	rick R	d Ba	l mary	rland, Ir	1228		
Physician		299 Frederick Rd Baltimore MD 21228 23a. Part I. Enter the divease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and												
/Medical Examiner	ı	Immediate Cause (Fin	al disease		gunshot	wound of	head					Death		
		or condition resulting i	in death)	Due to (or as a	consequence of	of):								
36. 47	ē	Sequentially list condition if any, leading to imme		Due to (or as a	a consequence of	of):								
	aminer	(Disease or injury that	initiated	C.		-f)								
ted 1 ansit	ω̈	events resulting in dea	ath) Last	d Due to (or as a	a consequence of	O1)								
0, e be executed sician and	edical	X UNPENDED		AMENDED	i+~#220	27 29a_f	,perME,g86	50 10/2	/06 T					
60, sate be shysici ne buri	Med	IF FEMALE:		23c. If yes,	outcome of preg		, perrin, go	50,10/2/	700 1.		23d Date of delivery			
6876 certificate rding phy	hysician/M	23b Was decedent pre past 12 months?	egnant in the	1 Live	birth nant at time of de		tal death 3	Ectopic	pregnand	су	Month	Day Year		
Box e death of the atter	ysic	1 Yes 2 No	9 Unkno			eatri 5 O	ther (Specify)							
cords, P.O. Box 68766 Iaw requires that the death certificate has been signed by the arrending phy 2 should be detached for use as the U	۱-	Part II. Other significa	ant conditio	ns contributing t	o death but not	resulting in the	underlying cause	given in Par	t I.	23e Did t	obacco use contril	bacco use contribute to the cause of death?		
, P. rres that signed be de	d by									1 Ye	s 2 🗸 No 3	Probably 4 Unknown		
ords v requi	lete									24a Was auto		Vere autopsy findings available prior to completion of cause of		
Pecc The lay age 2	The cords: The c								leath? ✓ Yes 2 No					
= E 5 a 25 Was case referred to medical 26.Place of Death (Check only one)														
Nysic Physic	To B	1 Y Yes 2	No	Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other:										
n of ding Ph		27 Manner of Death 1 Natural	5 Pendir		h, Day, Year)	28b. Time of	1	ury at Work? Yes 2 🔻						
Siol Atten r death ector: by the	cati	2 Accident	Investi	gation 9/10	/2006	5:00 am	et, factory, office	71			shot self			
Division spital or Attendin hours after death meral Director: A filled in by the fu	Certification:	3 X Suicide 6	Could determ	not be			on, radio.y, o	g ₁		Baltimo	state) MD 432 S	er or Rural Route Number, City S. Hanover St.		
Hospi 24 hou Funer ely fil		29a Certifier 1 Ce	ertifying Phy	sician: To the be	st of my knowled	dge, death occu	rred at the time,	date and plac	ce, and d	ue to the cau	se(s) and manner	as started.		
Subject shot Subject Shot Shot Subject Shot Sh										and place, and di	ue to the cause(s)			
29b. Signature and title of certifier 29c License number 29c License number										ed (Month, Day, Year)				
00	O.C.M.E. September 12, 2006										12, 2006			
A Light		30 Name and address Carol Allan, M		no completed cau			Street, Baltir	nore MD	21201					
	ate	31. Date filed (Month			49						_			
	State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar													

		For State Registrar	State	of Mar		artment of F					06	29217
		Decedent's Name (First, Middle	, Last)						Date of Dea Month		Year	3. Time of Death
Physicia /Medic		Virginia L	ee Hilli	er				S	eptemb	per 14,	2006	6:00A M
Examin		4a. Facility Name (If not institution		-		4b. City, Town, o		of Death		4c. County		1
		5813 Judge Dob	6. Sex		'In yrs. last birthday	Elkr		24 Hrs. 8	Date of Birth	1	Howa 9. Birtho	rd place (State or Foreign
Funeral Director		251-46-5260	1□M 270F	,go (71 Yrs.	Months Days	Hours	Min.	Month, Day	1935	Coun	th Carolina
P .		Usual Residence of Decedent			0c. City, Town or L							0d. Inside City Limits
ehov	ō	Maryland Howar	ad	'	Elkri							1 ☐ Yes 2X No
28a-f	Directo	Maryland Howan	<u>.u</u>		ETKLI	10f. Zip Code				10g. Citizen of \	What Cour	itry?
3a or		5813 Judge Dob	bin Cour	t			1075			1	USA	,
deati	Funeral	11. Marital Status	12. Was De Armed F	cedent Ev	er in U.S. 13.	Was Decedent of H	tispanic Or an, Mexica	rigin? (Specif	y Yes or No-	14. Rac	e - Americ	
s after	by Fu	1 ☐ Never Married 2 ☐ Marri 3 🛣 Widowed 4 ☐ Divorced	ied 1 🗀 Yes	: 2∭∑No ≩ive		1 ☐ Yes 2 💆 No	Specify.		,		w Whi	
ING 21215-UU35 be filed within 72 hours after death with the Maryland ital Hygiene. Ind other then "natural", or items 23e or 28e-f ehow event, the Medical Examination and be notified at	ed b	15. Decedent	Year or	Dates:	16a. Dec	edent's Usual Occur	oation			16b. Kind of Bi	usiness/Inc	dustry
C L 22	plet	(Specify only highes Elementary/Secondary (0-12)		d) (1-4or 5+)	life.	e kind of work done DO NOT use retire	during mos d)	st of working				
Med wit	Completed	12				eptionist	T				ospit	al
Maryland 2 Id 2 should be filed in and Mental Hygic It is marked other treumatic event, III	Be	17. Father's Name (First, Middle,							First, Middle, 1. Ham	Maiden Suman	ne)	
aryla should ind Men marke umatic	ဥ	Carlisle C. Ha	-		19b. Mai	ing Address (Street	-				State, Zip	(Code)
	- 1	Robyn Spurrier				Judge Do				-		
of Height		20a. Method of Disposition 1 ☐ Burial 2 🌣 Cremation	2 Domewal from	m State	20b. Place of Disp cemetery, cre	osition (Name of ematory or other pla	ce)	Date	9	20c. Location -	City or To	wn, State
Pages Pages ment of ant: If it		4 ☐ Donation 5 ☐ Other (S	pecify)	ii State	and the second s	ematory I		09/15/				Maryland
Baltimore, permit. Pages 1 e Depertment of Hee important: if item eny injury or othe		21. Signa we of Justial Service Thomas Great	or ()		2	Cremation 299 Frede	Soci Soci rick	ety 01 Road I	f Mary Baltim	land, In	nc. rylar	nd 21228
		23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that	t caused the	ne death. Do not ea	nter the mode of dyi	-			rest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	_a. \	reto	estatic	hunc	3	anc	er		1	Onset and Death O Months
/Medical Examiner		resulting in death)	Due to	o (or as a	consequence of):	e Pai	n					
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cuted	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	G						_			
50, e exe ien ar urial-t		resulting in death) Last	Due to	o (or as a	consequence of):							
58 760, icate be executed physicien and s the burial-transit	dical		d		·							
= 0 ⋅ 0 ⋅ 0 ⋅ 0 ⋅ 0 ⋅ 0 ⋅ 0 ⋅ 0 ⋅ 0 ⋅ 0	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o							23d. Da	te of delive	erv
by the ettendin	iciai	in the past 12 months?	4□Pre	gnant at tir		□Ectopic pregnanc □ Other (s <i>pecify)</i> _	у				onth	Day Year
P.O	phys	9 Unknown	9∐ Unk									
dS, P		Part II. Other significant condition	ns contributing to	death but	not resulting in the	underlying cause gr	ven in Part	1.		ibacco use cont ′es 2 □ No	3 Prob	ne cause of death?
COrd w requir been si	eted				<u>-</u>							
VITAI RECORDS, sicien: The law requires to contificate has been signe irector, page 2 should be e	ompleted								24a. Was a autop perfor	med?	prior to co death?	psy findings available mpletion of cause of
	C	25. Was case referred to medical					26. Plac	e of Death (│ 1 ☐ Yes Check only o		1 🗌 Yes	2 No
	To B	examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1	npatient	2 ER/Outpatie	INT 3LI DOA		ursing Home	5 🗆 Resid	ence 6 10th	er (Specif	Residence
DIVISION OF I or Attending Phy after death. Director: After this 3 in by the funeral d		27. Manner of Death t ☑Natural 5 ☐ Pendin	ig (Mo	e of Injury onth, Day	Year) 28b. Time Injury	Wo			d. Describe h	ow injury occur	red	
Attend death ctor: y the f	Icat	2 Accident investig	not be 390 Pta	ce of Injury	/ - At home, farm, s		Yes 2		Location (S	itreet and Numb	er or Rura	al Route Number.
<u>> 2 € 7 ∈</u>	Certification:	4 ☐ Homicide determ	buil	lding, etc.	(Specify)	,			City or Tow			
To the Hospital within 24 hours a To the Funerel I completely filled	edicai (29a. Certifier (Check only one) Certifyin	Examiner: On the	he best of basis of e	xamination and/or i	th occurred at the tr nvestigation, in my	me, date a opinion, de	nd place, and ath occurred	d due to the o	cause(s) and ma date and place,	anner as st	tated. the cause(s)
To the Hos within 24 h To the Fun completely	Me	29b. Signature and title of certifie				29c. Licen:			1	29d. Date signe	d (Month,	Day, Year)
7) once	M.D.				554	413		9/	14/0	16
6		30. Name and address of person	who completed ca	use of dea	ith (Item 23a) (Type	, Print)	t.	ROUT	more	AAD	2.	77-
V)		31. Date filed (Month, Day, Year)			5. Han	over 2	19 4	swou,	IWIL	עוייו	~10	V 5
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State of Maryland / Department of Health and Mental Hygiene 2006 29219 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) September 11, 2006 **Physician** 12:45 PM Harry Brand Heeb, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Brighton Gardens Baltimore Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Sept 22, 6. Sex 1 ☑ M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 295-26-1623 75 Yrs. Ohio Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ul Hygiene. . other then "neturel", or items 23a or 28a-f show vent, the Medical Exempler must be notified at 1 Yes 2 No Funeral Director Baltimore Baltimore 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 6451 N. Charles St. 21212 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, Whife, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: Completed by 3 XWidowed 4 ☐ Divorced white 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) V.P. Sales Engineering Company permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie important: if item 27 is marked other It eny injury or other traumatic event. Its once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Florence Hathaway Harry Brand Heeb, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia L. Hoff daughter 4815 Bart Allen Lane; Baldwin, MD 21013 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Shrine of Rest Maus. 9/15/06 4 Donation 5 Dother (Specify) entombrent Fond du Lac, WI 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complitations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only of cause on each line. fmmediate Cause (Final Coronary **Physician** yens disease or condition resulting in death) /Medical Due to (or as a consequent of): Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner ed by the attending physicien and detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliven 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No certificate has 1□ Yes 2⊠No : After this certifical tuneral director, 25. Was case referred to medical 26. Place of Death | Check only one) examiner' Hospitaf: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASSU Fed Wing Certification: To 1 Yes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending neral Director: A 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stafe) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier September 1/2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMUN CHEN LOW 660 N. CHEN lades St Barne up 21200 6601 N. Charlesus 31. Date filed (Month, Day, Year) SFP 1 4 2006 32. Registrar's Signature SEP 14 Registrar

Medical E	nysician Examine
ith the Maryland	23a or 28a-f show any 95 notified at once.

Please Type or Print in Black Indelible Ink

Headspeth		1- For State	te of Maryland		nent of cate of		Mental Hy	/giene _{Reg}	No. 2	006 2	0220
Physicia ical Examii	an/	Registrar 1. Decedent's Name (First, Middle, Trone	Last) Durre	ell		Headspe	th	2 Date of Death	Dav Year	3. Time of D	eath
)		4a. Facility Name (if not institution, University of Maryland			4	b. City, Town, or L Baltimore	ocation of Death		4c. County of	f Death	
Funeral Director			. Sex 7	Age (In yrs. last b	oirthday) Yrs	If Under 1 Year Months Days	If Under 24Hrs Hours Min	8. Date of Birth		Birthplace (State Foreign Country)	or MD
ow any		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow						10d Inside	
with the Maryland ns 23a or 28a-f show any be notified at once.	Director	MD NA 10e. Street and Number			timor	10f. Zip Code		109	Citizen of Wha	at Country?	
3 2	Funeral D	249 South Lou 11. Marital Status 1 X Never Married 2 Mar	12. Was Decede	ent Ever in U.S.	13. Wa	2122 s Decedent of Hisp es, specify Cuban,	anic Origin? (Sp	ecify Yes or No- Rican, etc.)	U • S 14 Race · White	American Indian, B	lack,
ਨੂੰ ਰੂਜ਼	۵		1 Yes ced If Yes, Give Year or Dates. y only highest grade of	No No No No No No No No No No No No No N	a Deceden	Yes 2 X No t's Usual Occupations of working life.	on (Give kind of v		Specify: 6b Kind of Bus	Black siness/Industry	
nore, MD 21215-0036 gaes I and 2 should be filed within 72 hours after nt of Health and Mental Hygiene II fittem 27 is market other than "natural"; other transmatic event, the Medical Examiner	Completed	Elementary/Secondary (0-12) 10th grade	College (1-4	or 5+)		Student		(First, Middle, Ma		hool	
		17. Father's Name (First, Middle, L Antrone Heads 19a. Informant's Name/Relationshi			19b. Mailing	Address (Street	Svlvi	a Hill		n, State, Zip Code)	
imore, MD 2 Pages I and 2 shoul ment of Health and M tant: If item 27 is m or other tranmatic	_	Cierra Stokes 20a. Method of Disposition	-Sister		249 Se of Dispos	South Lo	etery, A	ve Apt	B Ba 20c Location -	1 to, Md City or Town, State	21229
Baltimore, permit Pages I a Department of He Important: If it injury or other I		1 X Burial 2 Cremation 4 Donation 5 Other Special Signature of Funeral Service L	cify.	State	g Mer		Park 9/	16/06	Randa	llstown	Md
m ଲୁଗୁମାନ Physician	1	23a Part I. Enter the disease, or of failure. List only one cause of	omplications that caus	sed the death. Do	not enter t	BOO Waba he mode of dying,	ash Ave	Balt:	more, t, shock, or hea	Md 212	ate Interval Onset and
/Medical Examiner		mmediate Cause (Final disease or condition resulting in death)	a Multiple Injuri							De	eath
d.	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a co	onsequence of):							
recuted n and - transit	al Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of):							
60, ate be ex shysician e burial	Medic	UNPENDED IF FEMALE:	23c If yes, ou	item#1.pe	rME.g85	59,9/21/06	IT		23d. Date of	delivery	
Box 68760, e death certificate be execut the attending physician and ed for use as the burial - tra	sician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unki	4 Pregnan	t at time of death	4 1	etal death 3 ther (Specify)	Ectopic pregna	ancy	Month	Day	Year
P.O. Be sthat the de gned by the detached f	by Phy	Part II. Other significant condition	3 _ GIRIOW		Iting in the	underlying cause g	iven in Part I			bute to the cause of	
ing Physician: The law requires that the death certificate be executed fing Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and uneral director, page 2 should be detached for use as the burial - trans	Completed					_		24a. Was a autops perform	y ped? c	Vere autopsy finding erior to completion of leath?	cause of
II Re	1 0	25. Was case referred to medical					of Death (Check	1 ✓ Yes 2 only one)	No 1	Yes 2	No
Vita	10 B	examiner? 1 ✓ Yes 2 No		patient 2 🗸 EF				ng Home 5 F	Residence 6	Other:	
ion of Vi trending Physi leath rfor: After this		27. Manner of Death 1 Natural 5 Pend 2 ✓ Accident Inves	tigation	Pay Year) 2	8b. Time of 102 hrs	1 1	ry at Work? (es 2 ✓ No	Pedestrian s	truck by aut	0	
Division spital or Attendii tours after death neral Director: Affilled in by the fi	Certification:	4 Homicide deter	mined (Specify)	Local Street		eet, factory, office b		or Town, St 2400 Block o	of West Fran	er or Rural Route Nunklin Street, Bal	
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certificompletely filled in by the funeral director,	Medical	(Check only one) 2 Medical Example 29b. Signature and title of certifie	nysician: To the best niner:On the basis of and manner sta	examination and	death occu	arred at the time, da ation, in my opinion 29c. Licens	, death occurred	at the time, date a	nd place, and c	as started lue to the cause(s) ed (Month, Day, Yea	ar)
d	≥	Caldel	COLT	K.	2-1	O.C.			September		
5			Assistant Medica	I Examiner	111 Pe	nn Street, Balt	imore, MD 2	1201			
S Regis	State stra	A	4 2006 32. Re	strar's Signature	4. 1	neel!					

DHMH 17 Rev 1/2001 OCME 2006

			For State Registrar	State of Marylan		irtment of I tificate of			iene ag. No. 200	6 29221
i	Physici		1. Decedent's Name (First, Middle, Last) Julia		Ham	ilton		2. Date of Deat Month 9	7 Day 2006	3. Time of Death 10:25a M
)	/Medic Examin		4a. Facility Name (If not institution, give str 1821 Wentworth Ro			4b. City, Town, Parkv	or Location of Death	1	4c. County of De Baltir	
	Funeral Director		212-34-9383	7. Age (In yrs.	ast birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day)	Year)	Birthplace (State or Foreign Country) Md.
	e Maryland a-f ahow	Director	Usual Residence of Decedent 10a. State 10b. County Md. Baltimor		y.Town orLo Parkvil	lle				10d. Inside City Limits 11 Yes 2 □ No
	th with th		10e. Street and Number 1821 Wentworth F	load		10f. Zip Code 21	234	1	0g. Citizen of What USA	
336	urs after dea ai', or Items	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	,	Was Decedent of fYes, specify Cub	Hispanic Origin? (S pan, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)	Black, W	merican Indian, hite, etc. Black
aryland 21215-0036	ges 1 end 2 should be filed within 72 hours after death with the Maryland to f Heelih and Menial Hygiene. It is the marked other than "natural", or items 23a or 28a-f ahow if item 27 is marked other than "natural", or items 23a or 28a-f ahow or other traumatic avant, the Medical Examinal must be notified at	Completed	15. Decedent's Educe (Specify only highest grade		(Give		pation oduring most of word Developn		16b. Kind of Busine Dunbar De Services	ss/Industry pt. of Social
and 2	S should be filed v and Mental Hygie is markad othar t aumatic avant, ib	To Be Co	12th grade 1 17. Father's Name (First, Middle, Last) Isaiah	Ar.	arfiel			me (First, Middle,		
Mary	nd 2 should belth and Meni	-	19a. Informant's Name/Relationship (Type T.C. Hamilton	e, Print) Husband		•	tand Number or Ruth Road,		e, Md. 2	e, <i>Zip</i> Code) 1234
altimore,	Pages 1 end nent of Heelth int; if item 27 iry or other to		20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State	Place of Dispo emetery, cren	sition (Name of natory or other pla	ace)	Date	20c. Location - City	or Town, State del Co., Md.
Baltii	permit. Pages Department of Important; if i any injury or once.		21. Signature of Funeral Service Licensee		22	. Name and Addr	ess of Facility	March F.H		21202
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the deat e cause on each line. Due to (or as a consequence)	cell	er the mode of dy	•	c or respiratory arr	est,	Approximate Interval Between Interval Between
8760,	icete be executed physicien and sthe burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)						
.O. Box 68	The law requires thet the death certifica sie hes been signed by the attending ph page 2 should be deteched for use as I	by Physician/Medicai	IF FEMALE: 23b. Was decedent prégnant in the past 12 months? 1 ☐ Yes 2 55 No 9 ☐ Unknown	ic. If yes, outcome of pregnation 1 Live birth 2 Feta 4 Pregnant at time of c	Ideath 3	Ectopic pregnan	су		23d. Date of Month	delivery Day Year
α.	quires thet n signed by uld be dete		Part II. Other significant conditions cont	ributing to death but not res	ulting in the u	nderlying cause g	iven in Part I.	23e. Did to		e to the cause of death?
Division of Vital Records,		Completed						24a. Was a autop: perfor	sy prior med2, death	autopsy findings available to completion of cause of 1? /es 2 No
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital: 1 Inpatient 2	ER/Outpatier	nt 3□ DOA O	26. Place of De ther: 4 ☐ Nursing I	ath Check only or		Proceeds.
ion of	Attanding Physic death. actor: After this by the funeral di	ation: To	1 Yes No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Inj			ow injury occurred	pecity
Divis	P # F	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, str	reet, factory, office)	28f. Location (S City or Tow	treet and Number or m, State)	Rural Route Number,
	Hospital 24 hours a Funeral C	edical		ician: To the best of my known: On the basis of examination and manner stated.						
	To the Within 2 To the comple	Me	29b. Signature and title of certifier			29c. Licer	nse number		29d. Date signed (M	onth, Day, Year)
T il	1		30. Name and address of person who con	mpleted cause of death (Itel	n 23a) (Type.	Print)	4944		ERES	a 822006
1			STMLEY WALLE	EE OWN	33-NO	nt co	retur	ect By	throne	m) 2/2/8
	St Regist	ate	31. Date filed (Month, Day, Year) CFD 1 / 20	32. Registrar's Sign	Ature A	carle				

06-06817 Adrian Holiday

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

dilan Holiday		1- For State Registrar	.e or ivial yland /	•	ate of Death			eg No. 201	16 2922
Physicia Medical Exami	in/	Decedent's Name (First, Middle,	_ast)	77-7			2 Date of Deat Month	Day Year er 10, 2006	3. Time of Death 0231 hrs
Wedical Exami		Adrian 4a, Facility Name (if not institution,	give street and number)	HOT	iday 4b. City, Town,	or Location of Deat		4c. County of Dea	
		Johns Hopkins	,		Baltimore			NA	
Funeral		Social Security Number 6	Sex 7. Age	e (In yrs. last bir			_	th(MM/DD/YYYY) 9. B Fore	
Director			XM 2 F	19	Yrs Months E	Days Hours Mit			ountry) Md.
any	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d Inside City Limits
*	_	Md.	NA	Ba	ltimore				1 X Yes 2 No
Maryland 28a-f show d at ouce.	Director	10e Street and Number			10f. Zip Cod	е	1	0g. Citizen of What Co	untry?
th the Maryland 23a or 28a-f sho notified at once		1710 Normal Av			21213			USA	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene 7 is marked other than "natural", or items 23a or 28a-f she arife event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 X Never Married 2 Mari	12. Was Decedent Armed Forces?		 Was Decedent of If Yes, specify Cu 	Hispanic Origin? (S ban, Mexican, Puert		14. Race - Ame White, etc	rican Indian, Black,
ter des		**	1 Yes 2	X. No	1 Yes 2 X	No specify		Specify Bla	ick
ours af atural	d by	15. Decedent's Education (Specif	y only highest grade com	pleted) 16a.	Decedent's Usual Dccu during most of working	ipation (Give kind of		16b. Kind of Business	
6 n 72 h an "n ical E	Completed	Elementary/Secondary (0-12)	College (1-4 or 5			mc. DO 110 1 doc 10	ui ca)		
5-0036 led within 7. Hygiene other than the Medical	mo	12th grade 17. Father's Name (First, Middle, L	l yr.		Student	18.Mother's Nam	ne (First, Middle, I	NA Maiden Surname)	
21215-0036 wild be filed within 7 Mental Hygiene marked other than cevent, the Medica	BeC	James	,	Holiday	, Sr.	Ver		Richardso	on
D 2121 should be f and Mental 7 is marked natic event,	10 E	19a. Informant's Name/Relationshi	(Type, Print)	119	9b. Mailing Address (S	treet and Number or	Rural Route Nun	nber, City or Town, Stat	e, Zip Code)
md 2 shou ealth and N tem 27 is n		James Holiday, 20a. Method of Disposition	Sr. Fath		1710 Normal of Disposition (Name of		Baltimo	re, Md. 2]	.213
2 - E E = 1		1 X Burial 2 Cremation	3 Removal from Sta	ate crema	itory or other place)	· .		1	,
Baltimor permit Pages I Department of I Important: If		4 Donation 5 Other Spe 21 Signature of Funeral Service L	cify:	Arbu	tus Mem. Pk		15-06	Arbutus,	Ma.
Balti permit Departo Imports		21 Signature of Funeral Service L	censee	$\overline{)}$			March F enue, Ba	.H. East ltimore, Mo	1. 21202
Physician	Н	23a. Part I. Enter the disease or ca failure. List only one cause o		the death. Do r	not enter the mode of dy	ing, such as cardiac	or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease	a Shotgun Wound						Death
- Examiner		or condition resulting in death)	Due to (or as a conse	equence of):					
San San San Carlo	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	equence of):					
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	c. Due to (or as a conse	equence of):					-
inted id ansit		events resulting in death) Last	d.	34401100 017.					
760, reate be executed physician and the burial - transit	Medical	UNPENDED	AMENDED		-				
760, icate be to physicia the buria	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcor	ne of pregnancy		3 Ectopic pregr		23d Date of delive	
	/sician/	past 12 months?	4 Pregnant at	time of death	Fetal deathOther (Specify)	3 Ectopic pregr	nancy	Month	Day Year
	Physi	1 Yes 2 No 9 Unkn	own 9 Unknown					Ĩ	
국 # A A A A	by PI	Part II. Other significant condition	ns contributing to deat	h but not resulti	ng in the underlying cau	se given in Part I		obacco use contribute t	o the cause of death?
S, P.C							24a Was		autopsy findings available
ords aw requi nas been 2 should	Completed						autop		completion of cause of
Rec The I	Con					I Charle (Obs.)		2 No 1 V	res 2 No
f Vital Reco Physician: The law er this certificate has ral director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital.	ent 2 V ER/		Other Nurs	sing Home 5	Residence 6 Oth	er
Ph Ph	: To	1 ✓ Yes 2 No 27. Manner of Death	28a Date of Inju	ıry 28b		Injury at Work?	28d Describe	how injury occurred	
Division of Vital Records, talor Attending Physician: The law requir us after death and Director: After this certificate has been s led in by the funeral director, page 2 should I	Certification:	1 Natural 5 Pendii		(ear) 02	15 hrs 1	Yes 2 V No	Subject was	sshot	
Division pital or Attent ours after death teral Director: filled in by the	ifica	2 Accident Invest 3 Suicide 6 Could		jury - At home,	farm, street, factory, offi	ce building, etc	28f Location (or Town, S		Rural Route Number, City
Diversity ours a filled	Cert	4 Homicide determ	nined (Specify) LD	cal Street				of East 22nd Stree	et, Baltimpre, MD
Division o To the Hospital or Attending within 24 hours after the To the Funeral Director: After completely filled in by the fune			vsician: To the best of mainer: On the basis of exa						
To tl To tl com	Medical	29b. Signature and title of certifier	and manner stated	/		cense number		29d. Date signed (M	
d	37	\cap	11/	-/		.C.M.E.		September 10,	
1		30 Name and address of person v	who completed cause of	death (Item 23a)				
H		Jack Titus MD. Depi	uty Chief Medical E		111 Penn Street, I	Baltimore, MD 2	21201		
		31 Date filed (Month, Day, Year)	2006 32. legistra	ar's Signature	Could				
Regis	1(3)	SEP 14	F000	-	1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 11:00 AM Donald Johnson 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Mercy Medical Center Baltimore 8. Date of Birth (Month, Day, Year)

June 2 1949 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 219-52-5733 1**X**M 2□F MD Director Usual Residence of Decedent the Maryland 10a. State 10b. County A.A 10d. Inside City Limits 10c. City. Town or Location worle th and Mental Hygiene. 17 is marked other then "naturel", or iteme 23a or 28a-1 ehov traumatic event, the Madical Examinat must be nutified at 1 Pes 2 No Director MD 3a Himore 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 21205 /a Shing for 12. Was Decedent Ever in U.S. Armed Forces? 1021 Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 Married ☐Yes 2000 Baltimore, Maryland 21215-0036 1 Yes 2410 Specify: If Yes, Give Year or Dates: þ Specify: 3 ☐ Widowed 4 ☐ Divorced BlackCompleted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Factory Lorker DICTOY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Johnson Josephin-l 2 JOSEPH 19a. Informan's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Heelth ar Important: if item 27 is eny injury or other trau once. Robinson 20b. Place of Disposition (Name of Date Baltimore, MD 21331 Niece 201 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 9-16-06 4 ☐ Donation 5 ☐ Other (Specify) 2 Corneter/ 9-16-06 Batton Cometen/ 21. Signature of Funeral Service Licenses 1129 N. Caroline St. Ba HO, MD 21813 alucia 23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cirrhosis unknown /Medical Due to (or as a consequence of): **Examiner** Hepatitis C unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Immunodefiziency Syndrome 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed Spontaneous Bacterial 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2★ No After this certificate Hepatic Encephalopathi 25. Was cas referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours efter death
To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospitai 12 Cartifying Physician: To the bast of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 20a Cariffion (Check only 29b. Signatyre and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JEFF LIVERSREIN, MD 2 haddress of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

ZILBERSTEIN

31. Date filed (Month, Day, Year) SEP 1 4

MD

2006

32. Registrar's Signature, 16

A Bush

5

BALTMERE

			1 - For State Registrar	State of Mary	•	artment of rtificate of			Reg. No. 200	6 29224
-	Physici	an	Decedent's Name (First, Middle, La					2. Date of De	 Day Year 	3. Time of Death
pain	/Medic	al	Frederick 4a. Facility Name (If not institution, give	William	Jupit	T	or Location of Deat	SETTEM	4c. County of Dea	
	Examir Funeral Director		BALTIMORE WASHIN 5. Social Security Number 6. S 215-01-6359	GTON MEDICA	L CENTEL yrs. last birthday, Yrs.	61	EN BUI	2NiE ■ 8. Date of Birt	ANNE F	PUNDEL Thplace (State or Foreign ountry) ryland
	and	}	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or L	ocation				10d. Inside City Limits
	death with the Maryland me 23a or 28a-f show rrunt be notilied at	to	Maryland Anne Ar	ındel	Pasaden	а				1 ☐ Yes 2 ☐ No
	h the	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
	23a c	ai	504 Grays Creek 1	Road		2112	22		United Sta	ates
21215-0036	or its	by Funeral Directo	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☑ Yes 2 ☐ No If ¥es, Give Year or Dates:	r in U.S. 13.	Was Decedent of If Yes, specify Cult 1 ☐ Yes 2 ☐ No	Hispanic Origin? (S ban, Mexican, Puer o <i>Specify:</i>	Specify Yes or No to Rican, etc.)	0 1	
5-0	n 72 hours "natural", Idical Exe	eted	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give	dent's Usual Occu	during most of wa	nrking	16b. Kind of Business	/Industry
121	within ne. han	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	9d)		61	
	Hygie Hygie ther t	ပိ	8 years 17. Father's Name (First, Middle, Last	n/a	Lon	gshoreman		me (First, Middle,	Shipping Maiden Sumame)	
Maryland	ges 1 and 2 should be filed within to of Heelth and Mental Hygiene. If item 27 is marked other than or other traumatic event, the Me	To Be	Carl E. Jupitz				Anna		maidon gamamo,	
ary	shoul and Mari	F	19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ing Address (Stree	t and Number or R	ural Route Numbe	er, City or Town, State,	Zip Code)
	es 1 and 2 s of Heelth ar f item 27 is r other trau		Phyllis Jupitz (reek Road	Pasaden	a, Maryland	21122
ore	of He of He If item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Pemoval from State		matory or other pla		Date	20c. Location - City or	
Baltimore,	nit. Pag vartment ortant: Injury o		4 Donation 5 Dother (Special	y) (Glen Burnie	
Ba	permit. Pages Department of I Important: If its eny injury or o	l o	21. Signature of Funeral Service Lice	Wayne Oste	100 m	2. Name and Addr CCully-Pc 204 Mount	olyniak Fi Lain Road	uneral He Pasadena	ome, P.A a, MD 21122	
	Phonetoton		23a. Part1. Enter the disease, or com- shock, or heart ailure. List only Immediate Cause (Final	one cause on each line.	-0. 6	ter the mode of dy	ing, such as cardia	c or respiratory ar	rest,	Approximate Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a 96	nsequence of):	77	1 7) c	· 	
	Examiner	er	Sequentially list conditions,	b. Menta	W7v	view	thin!	12 ten	ction	
Jm.	uted J ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a co	onsequence on S	tens	Cro			
0,	ite be executed iysicien and ne burial-transil	Exa	resulting in death) Last	Due to (or as a co	on squence of):					
8760	9 % 0	dicai	•	_ d						
P.O. Box 68	the death certifical y the ettending phy ched for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnand Other (specify)	су		23d. Date of de Month	olivery Day Year
	v requires that the de been signed by the should be detached	y Ph	Part II. Other significant conditions	contributing to death but no	ot resulting in the u	ınderlying cause g	iven in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
rds	requires een sign sould be							1 🗆 1	/es 215400 3□P	robably 4 Unknown
Division of Vital Records,	e lav	Completed							sy prior to rmed? death?	utopsy findings available completion of cause of
tai	ilcian: Th certificate rector, pag	BeC	25. Was case referred to medical				26. Place of De	1 ☐ Yes ath (Check only o		s 2000
Ž	nystci Nis cer I direc	일	examiner? 1 ☐ Yes 2 No	Hospital:	2 ER/Outpatie	nt 3 DOA	than		lence 6 □Other (Spe	ecify)
o u	ling PI After th unera		27. Manner of Death 11	28a. Date of Injury (Month, Day Ye	28b. Time (Injury	Wo		28d. Describe h	now injury occurred	
islo	Attend death octor:	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	10	At home, farm, st]Yes 2 □No	28f. Location (S	Street and Number or R	ural Route Number,
Ö	itel or / rs after el Dire	Certification;	4 Northcide	building, etc. (S	Specify)			City or Tow	vn, State)	
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funarel Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only one) (Check only 2 Medical-Example)	nysician: To the best of m niner: On the basis of exa and manner stated.	amination and/or in	th occurred at the to execute the top of the	time, date and place opinion, death occi	e, and due to the ourred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the To the comp	ž	29b. Signature and title of certifier	1000		29c. Licen	se number		29d. Date signed (Mon	th, Day, Year)
			1	(11)		JH.	3000	(14/12/21	006
	10+1		30. Name and address of person who	OKITEY	70	1 Aver	oital	Dr.1	65/2m	Barnia, mD
	Sta Registr		31. Date filed (Month, Day, Year) SFP 1 4 2	32 Aegistrar's	Signature	mark)				

3

JUPITZ, TREDERICK

Please Type or Print in Black Indelible Ink

Jones		State of Maryland 1- For State Registrar	Certificate			Do	. No.	006 00	
Physicia al Exami	ian/ iner	1. Decedent's Name (First, Middle,Last) Pansy A.		Jones		2. Date of Death Month September		0 6 2 0 Frime of Bear 0612 hrs	2
		4a. Facility Name (if not institution, give street and number Sinai Hospital	r)	4b. City, Town, or Lo	ocation of Death		4c. County	of Death	
Funeral Director		5. Social Security Number 6. Sex 7. Ag 1 M 2 F	ge (In yrs last birthda	y) If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	B. Date of Birth	,	9 Birthplace (State or Foreign Country) VA	
, any		Usual Residence of Decedent 10a State 10b. County	10c. City, Town or L	ocation				10d. Inside City	Limits
ith the Maryland 23a or 28a-f show notified at once.	ctor	MD NA 10e Street and Number	Balti	more	-	110	g. Citizen of Wh	1 XYes 2	No
the Ma 3a or 28 ofified a	Dire	3709 West Belvedere A	ve		215	100	U.S.	•	
items ust be	Funeral Director	11. Marital Status 1 Never Married 2 Married Armed Forces	?	. Was Decedent of Hispa If Yes, specify Cuban, N				- American Indian, Black e, etc.	ζ,
s after d ral", or niner m	þ	3X Widowed 4 Divorced If Yes, Give Year	2 X No 1	Yes 2X No			Specify	Black	
Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene in Friend Friend Friend I water all ", fant: friend 27 is marked other than "natural", or other traumatic event, the Medical Examiner	Completed	15. Decedent's Education (Specify only highest grade co Elementary/Secondary (0-12) College (1-4 or	durir	edent's Usual Occupation ng most of working life. D			16b. Kind of Bu	isiness/Industry	
l within giene ther tha	omo	8th grade na 17. Father's Name (First, Middle, Last)	Н	ouse Keep:	ing B.Mother's Name (I			g Home	
uld be filed with Mental Hygiene marked other tl	Be	Pastor Guy		1	Myrtle	Bennet	t		
2 should n and M 27 is m matic e	T ₀	19a Informani's Name/Relationship (Type, Print daug Vanessa V. Jones-John	son 73	ailing Address (Street a					
permit Pages I and 2 sh Department of Health and Important: If item 27 is injury or other tranmat		20a Method of Disposition 1 XBurial 2 Cremation 3 Removal from S	20b. Place of Dis	sposition (Name of ceme or other place)				City or Town, State	
t Page tment o rtant;		4 Donation 5 Other Specify	Arbutu	s Memoria		/06	Arbut	us, Md	
Depar Depar Impo		21. Signature of Funeral Service Licensee		22. Name and Address of March F/H 4300 Wabas	West	Dal+i	move	MA 21216	_
ysician		23a. Part I. Enter the disease, or complications that caused	1.00	TOUC Wabas	SH AVE	Dalli	more,	MO 2121:	
		failure List only one cause on each line.	d the death. Do not en	iter the mode of dying, su	uch as cardiac or r	espiratory arres	it, shock, or hea	Approximate In Between Onse	
Medical caminer		Informediate Cause (Final disease or condition resulting in death) a Hypertensive A Due to (or as a constitution)	therosclerotic Ca	iter the mode of dying, su ardiovascular Disea	uch as cardiac or r	espiratory arres	it, shock, or hea		
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	1 - State of Maryla Registrar	and / Department of Health and M Certificate of Death	lental Hygiene Reg. No. 2006 2	29226
Physician /Medical	Decedent's Name (First, Middle, Last) Dorothy	Johnson	Manth Day Voor	Time of Death
Examiner	4a. Facility Name (If not institution, give street and number) SAINT AUNES HOSPIT	4b. City, Town, or Location of Death AL BALTIMORE		
Funeral Director	5. Social Security Number 6. Sex 1 M 2 KF 79 Usual Residence of Decedent	rs. last birthday) Yrs. If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (Country)	State or Foreign Md.
h the Maryland rr 28a-f show rnotffled at		City, Town or Location		side City Limits
₹ ° 3 □	Md. NA 10e. Street and Number 2631 Maisel Street	Baltimore 10f. Zip Code 21230	10g. Citizen of What Country? USA	
5 2 2 5	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	n U.S. 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	perfy Yes or No-Rican, etc.) 14. Race - American Ind. Black, White, etc. Specify: Blace	
ted ted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of work) life. DO NOT use retired)	ng 16b. Kind of Business/Industry	
ind 21. be filed with that Hygiene do other thy event, the	Unkn 17. Father's Name (First, Middle, Last)	Packer 18. Mother's Name	Maryland Glass (First, Middle, Maiden Sumame)	co.
Maryland 21215 2 should be filed within 7 h and Mental Hygiene 'n reumatic event, tra Med To Be Comple	Will Meekins 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rura)
0, 5,5,5	Barbara Bethea Daughter 20a. Method of Disposition 1 & Burial 2 Cremation 3 Removal from State	4 Charleswood Ct., Ba D. Place of Disposition (Name of cemetery, crematory or other place)	Atimore, Md. 21207 Pate 20c. Location - City or Town, S	tate
Baltimore, permit Pages 1 at Department of Hea Important: If them any injury or othe	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Md. Vet. Cem. 9-14	-06 Crownsville, March F.H. East	1d.
D Pe D	Banah D Johnson 23a. Part 1. Enter the disease of complications that caused the deshock, or heart failure. List only one cause on each line.	1101 E. North Ave.	, Baltimore, Md. 212	oximate
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18760, cate be executed physicien and the burial-transit	that initiated events resulting in death) Last c. Due to (or as a cons	sequence of):	- 100 POID	V COVC
, W = 0 % P	IF FEMALE:			2
Division of Vital Records, P.O. Box 6 lor attending Physician: The law requires that the death certificate this three this certificate has been signed by the attending to blicotor. After this certificate has been signed by the attending to his the funeral director, page 2 should be detached for use as ertification; To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 menths? 1 Yes 2 No 9 Unknown	etal death 3 Ectopic pregnancy	23d. Date of delivery Month Day	Year
Cords, P. wrequires thet is been signed by should be deta	Part II. Other significant conditions contributing to death but not	resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cau	1 _
of Vital Record nysician: The law requir this certificate has been s all director, page 2 should To Be Completed			24a. Was an autopsy fir prior to completing performand? 1	on of cause of
Vita Vicion: incion: rector,	25. Was case referred to medical examiner?	26. Place of Death		
Division of V or Attending Physis of Attending Physis of Control of the function of the property of the physic of	1 Yes 2 No Normalist 2 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28b. Time of 28c. Injury at	me 5 Residence 6 Other (Specify) 28d. Describe how injury occurred	
₹ # 5 ± 5 €	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 28e. Place of Injury - A building, etc. (Spe	at home, farm, street, factory, office	281. Location (Street and Number or Rural Rout City or Town, State)	e Number,
D To the Hospital or within 24 hours at the thouse of the Completely filled it.	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my leading to the basis of examiner: On the basis of examiner and manner stated.	knowledge, death occurred at the time, date and place, a ination and/or investigation, in my opinion, death occurr	and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the c	ause(s)
To the within to the company of the property o	29b. Signature and title of certifier Main, M.D.	29c. License number	29d. Date signed (Month, Dey, 1) SEP, 08, 2006	
4	30. Name and address of person who completed cause of death (I	3- CATON AVE, BALTIM		
State Registrar	31. Date filed (Month, Day, Year) 32 Registrar's Signature (Month, Day, Year)	gnature B. Agaski		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20a-20c.perFH. C860.10/2/06 WS
State of Maryland / Department of Health and Mental Hygiene

1- For Amend item# 23a, perMD, C860, 10/2/06 TC extilicate of Department

1- Registrar 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 4:30 P M 2006 SEP JAMES CONRAD KING /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **BETHESDA** MONTGOMERY NATIONAL NAVAL MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/06/1929 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months M 2□F 76 England Yrs 194-30-4603 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
ant: If item 27 is marked other than "natural", or iteme 23a or 28e-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State the Medical Examiner must be notified at 1 Yes 2 No MD Director Montgomery Village Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20886-United States 10524 Cambridge Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 25 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Caucasian Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Medical College (1-4or 5+) Elementary/Secondary (0-12) Physician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Oliver T. King Doris Hood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If itsm 27 is sny injury or other treu 9000. 39 W. Montgomery Avenue Rockville, MD 20850-Mr. John A. King/Son 20b. Place of Disposition (Name of Date Location City or Town, State 20a. Method of Disposition Bethesda, Uniformed Services Chesapeake Crematory Sep 5 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Inc. 2006 - Marylana 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Rapp Funeral & Cremation Services mo1358 933 Gist Ave. Silver Spring, Maryland 20910. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infine diata cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, 👉 resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) ☐Yes 2☐No should be detached the 9☐ Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 🔀 No 1 ☐ Yes Physician: filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 💢 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ٩ 1 ☐ Yes 2 📆 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; 27. Manner of Death Hospital or Attending 1 XNatural 5 Pending 1 Tes 2 No investigation 2 Accident Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. the the 29d. Date signed (Month, Day, Year) 29b. Signature and title oficertifie 29c. License number Sept os 2006 0101235548 (VA) NATIONAL NAVAL MEDICAL CENTER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BETHESDA MD 20889-5600 USN TIMOTHY M. QUAST LCDR MC 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2006 Registrar SEP 14

				1 - For State Registrar	State o	of Maryla	and / Dep <i>Ce</i>	artmen <i>rtificat</i>	t of H e <i>of L</i>	ealth a	and M	lental Hy	giene Reg. No. 20	06	29228
4	100	Physici /Medic	cal	Decedent's Name (First, Middle LEONORA 4a. Facility Name (If not institution)	STAUFFEN	KOCH		4h City	Town or	Location of	of Death	2. Date of De Septem	ber 11,		3. Time of Death 11:25AM
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		Funeral Director		5. Social Security Number 216-46-9440	6. Sex 1 □ M X (X) F	81	rs. last birthday, Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, Di August	8,1925		ace (State or Foreign Tand
		death with the Maryland ims 23s or 28s-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Balti			City, Town or L	ocation						10	0d. Inside City Limits 1 ☐ Yes XX No
		with the	Directo	10e. Street and Number 12261 Roundwood	Road #301			10f. Zip		1093			10g. Citizen of V	What Coun	try?
ACA	5-0036	72 hours after death natural', or items 2:	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Mar X ☑ Widowed 4 ☐ Divorced	M Van Ci	2 NNo	n U.S. 13.	Was Deced If Yes, spec		spanic Ori n, Mexicar Specify:		ecify Yes or N Rican, etc.)	o- 14. Rac Blac Specify	e - America k, White, e y: Whi	etc.
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9	land	should be filed and Mental Hygi marked other matic event,	To Be (17. Father's Name (First, Middle, Frederick Char)		en						eitel	, Maiden Sumam	16)	
38	Maryland	d 2 should the and 7 is mutant		19a. Informant's Name/Relations William Bradfor	ship (Type, Print) S Koch Sr	Sor	n 196. Maili	ng Address West	(Street a	Aver	or or Rura	Route Numb Baltimo	re, City or Town, re, Mary	State, Zip land	^{Code)} 21210
=	Baltimore,	permit. Pages 1 an Department of Heal Important: if Item 2 any njury or other once.		20a. Mathod of Disposition ✓ Mathod of Disposition ✓ Cremation ✓ Donation 5 ☐ Other (S	3 □Removal from Specify)	State L(b. Place of Dispo cemetery, cre Orraine	osition (Nar. matory or o Park	ne of ther place Ceme	tery		23/06	20c. Location - Baltimo		
mber	Balti	permit. Departmingertal		21 Signature of Funeral Service	Licensee	ena	Ris 2	2. Name an	d Addres				edefeld Fur altimore, N		THE PROPERTY OF STREET
Septem		Physician /Medical Examiner	ical Examiner	23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	(or as a one	leath. Do not en						rrest,	C	Approximate Interval Between Onset and Death
ENOTI	P.O. Box 68	ne death certific the attending p hed for use as i	Physician/Med	IF FEMALE: 23b. Was decedent pregpant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		ointh 2□F nantattime∢	etal death 3	□Ectopic pr					23d. Dat	e of deliver	ry Day Year
pehil	Records, P.	w requires that If been signed by should be detac	ted by Pr	Part II Other significant conditi	ons contributing to d	leath but not	resulting in the t	underlying c	ause give	en in Part I.			tobacco use conti		e cause of death?
2	al Rec	ician: The law r certificate has be ector, page 2 sh	Completed by									1 ☐ Yes	psy ormed2 2 No 1	rior to con leath?	osy findings available apletion of cause of
	Division of Vital	Attending Physician: r death. sctor: After this certifice by the funeral director, g	sation: To Be		Hospital: 1 28a. Date (Monigation	Inpatient 2 of Injury oth, Day Year	28b. Time of Injury		8c. Injury Work	er: 4□ Nu	irsing Ho		one) idence 6 Oth how injury occurr		Ho-pie
	Divis	ital or Att irs after de ral Direct led in by t	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 286. Place build	ing, etc. (Spe						City or To	Street and Numb wn, State)		
		To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	29a. Certifier Certifyi (Check only one)	ng Physician: To the Examiner: On the b and man	e best of my pasis of examiner stated.	knowledge, deat nination and/or in	h occurred ivestigation	at the tim , in my op	ne, date an pinion, dea	d place, th occurr	and due to the ed at the time,	cause(s) and ma date and place, a	nner as sta and due to	ated. the cause(s)
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	4	State Registrar Amend #18 per	te of Maryland FH G859 9	1 / Depa /14/ 9	irtment of H fificate of I	lealth and M Death	lental Hyg	giene Reg. No. 200	6 29230
Physicia /Medic	an	1. Decedent's Name (First, Middle, Last) BEATQICE (CA	AUFMAN	/			2. Date of Dea Month Septem	well 20	3. Time of Death
Examin		4a. Facility Name (If not institution, give street a NORTHWEST HOSPITAL (4b. City, Town, or RANDAL	Location of Death		4c. County of E	
Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2	7. Age (In yrs. le	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Date) 02/16/	v. Year)	Birthplace (State or Foreign Country) MD
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th the / or 28a- e rotifi	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	t Country?
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13-0030 172 hours after death with the Marylan 172 hours or Iteme 23a or 28a-f show circal Examinar must be notified at	þ	Arr 1 □ Never Married 21 Married 1 □	ned Forces? Yes 2X) No es, Give ar or Dates:		f Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto Specify:	Rican, etc.)	Black, V Specify:	Vhite, etc. WHITE
	Completed	15. Decedent's Education (Specify only highest grade comp. Elementary/Secondary (0-12) Co	lege (1-4or 5+)	(Give life. l		ation during most of work 000RDINAT		16b. Kind of Busine	·
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Dallimore, I permit. Pages 1 end Department of Healt important: if Item 2 any injury or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	I from State	emetery, crer UK AMU	sition (Name of natory or other place) JNO CONG.	09/13	Date 3/2006	20c. Location - City BALTIMOR	E, MD
Dealt permit. Departr importr any inj		21. Signature of Funeral Service Monage	izei	8	3900 REIS	TERSTOWN	ROAD -		S., INC. E, MD 21208
Physician		23a. Parti. Enter the disease, or complication shock, or heart failure. List only one au Immediate Cause (Final disease or condition	that caused the death se on each line.	Do not ent	er the mode of dyin	g, such as cardiac	or respiratory as	ATHY	Approximate Interval Between Onset and Death
/Medical Examiner		resulting in obality	Due to (or as a consequ USQO SG	ence of):					
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death certifi e ettending ed for use as	Physician/Medi	in the past 12 months?	res, outcome of pregna]Live birth 2 [Fetal]Pregnant at time of de]Unknown	death 3	Ectopic pregnancy Other (specify)	,		23d. Date of Month	delivery Day Year
Ords, F.C. requires that the sen signed by the hould be detached.	Ď	Part II. Other significant conditions contributions	ng to death but not resu			en in Part I.	23e. Did t		te to the cause of death? Probably 4 Unknown
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OT VITAL IN Physician: The this certificate ral director, page	BeC	25. Was case referred to medical examiner?	/		0.5	26. Place of Deal			
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Lo the Hospital Within 24 hours a To the Funeral I	Medical	29a. Certifier (Check only one) 1 Certifying Physician 2 Medical Examiner: Call	To the best of my kno n the basis of examina ad manner stated.	wledge, deat tion and/or in	h occurred at the tire to the	me, date and place, pinion, death occur	and due to the red at the time,	cause(s) and manne date and place, and	er as stated. due to the cause(s)
To the within 2 To the complete	Ž	29b. Signal was and title of certifier	1 MD		29c. Licens	34288		29d. Date signed (A	May 11th 2006
8	8	30. Name and address derson who complete	ed cause of death (Item	23a) (Type,	Print)	things	HYSA	itel Co	My 11th 2006
Sta Regist		31. Date filed (Month, Day, Year)	32, Registrar's Signa	ture	Wall of the second				

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State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No.2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year September 12, 2006 **Physician** 9:30 AM M Louis Simon Lorenzetti /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 9514 Beck Court Bethesda Montgomery 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/16/1928 Birthplace (State or Foreign Country)
 NY 5. Social Security Number 7. Age (In yrs. last birthday). **Funeral** Months Days Min 071-20-2174 Yrs. Director Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Mudical Examiner must be notified at 1 ☐ Yes 2 No MD Montgomery Bethesda Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20817-9514 Beck Court USA 238 r death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mrs 2 □ No If Yes, Give Year or Dates: WW24 Koreco itame Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: White ፩ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Television Station other than Elementary/Secondary (0-12) College (1-4or 5+) Film Editor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any lighty or other traumatic event size. Be Charles Simon Lorenzetti Angelina Zambotti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. David Lorenzetti/Son 9514 Beck Court Bethesda, MD 20817-20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Sep 15 Beltsville, Maryland Chesapeake Crematory 2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Rapp Funeral & Cremation Services mo1358 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Prostat Immediate Cause (Final disease or condition resulting in death) Metastatic **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown nythmia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 ☐ Nursing Home 5 Besidence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO D 20367 06 13 1241 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) riccard Dr. Rockville, MD 20850 Kalman 31. Date filed (Month, Day, Year) 327 Registrar's Signature State SEP 1 4 2006 Registrar

		4	For State Registrar	State of Marylan		nt of Health and I		ne 2006	29232
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	Examin	er	1	Facility	T	alto.		alA	
A _p .	Funeral			Sex 1	last birthday) If Und Months	er i Year If Under 24 Hrs. s Days Hours Min.	8. Date of Birth Month, Day, Ye	10.2 A 14 -	place (State or Foreign htry)
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	or 28a	lrect	10e. Street and Number	0		Zip Code	10g	. Citizen of What Cour	itry?
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Baltimore,	permit. Pages Department of I Important: If Ite any Injury or of once.		4 □Donation 5 □ Other (Spec 21. Signature of Funeral Service Lic	city) r	1A 12. Name	and Address of A cill	+ 16 2004 1	Dal 10, 14	ica PA
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ı			23a. Part1. Enter the disease, or co shock, or heart failure. List on				c or respiratory arrest	t,	Approximate Interval Between Onset and Death
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Box	leath certificat attending phy I for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	al death 3 □Ectopic	pregnancy		23d. Date of deliv Month	ery Day Year
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Records,	w require been si should	Completed					24a. Was an	24b. Were auto	opsy findings available
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Vital	ician: certific	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 suppatient 2	☐ ER/Outpatient 3☐	Others	ath Check only one	ce 6 ☐Other (Speci	rfu)
ō		on: To	1 Yes 27 No 27 Mann of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how		97
Division	Attending r death.	catle	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	t be 28e Place of Injury - At h	M nome, farm, street, fac	1 ☐ Yes 2 ☐ No	28f. Location (Stre	eet and Number or Rui	al Route Number,
Div	s after al Dire	Certif	4 Homicide determin	building, etc. (Spec.	ify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	City or Town,	State)	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical Certification:	29a. Certifier Certifying (Check only one)	Physician: To the best of my kn taminer: On the basis of examin and manner stated.	nowledge, death occur eation and/or investigat	red at the time, date and plaction, in my opinion, death occ	e, and due to the cau curred at the time, dat	use(s) and manner as e and place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of on her	p		29c. License number		d. Date signed (Month)	-
			<i></i>	Darkemo -	um 22a) /Time (Print)	D 00 574		9/13/0	6
	1		30. Name and address of person w	CSE MD 25 Ma	in Sty Sul	te za, feisters	TOWN, MD.	21136	
- Co	St Regist	ate rar	31. Date filed (Month, Day, Year)	Des riogistrar s orgi	Sauli				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 1510 PM JR. Robert Lutz 10 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimera City Baltimore Maryland Shode Iraina University of 9. Birthplace (State or Foreign WEST Virginia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth OCT. 19 7. Age (In yrs. last birthday) Social Security Number 6/Sex 1 M 2 □ F **Funeral** Months Yea 1946 Min 59 Days Hours 577-64-6750 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County in then "natural", or iteme 23a or 28e-f ehow the Medical Examiner must be notified at Finksburg 1 ☐ Yes 2 No Carroll Md. **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21048 1537 Deer Park Road 12. Was Decedent Ever in U.S. Armed Forces? 1 (1) Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Whi te 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify þ 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Equipment Specialist U.S. Government permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygies
Important: If item 27 is marked other tt
any injury or other traumatic event, this
page. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Robert D. Lutz, Sr. Margaret Laurel Gribble 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1537 Deer Park Rd. Finksburg, Md. 21048 Mrs. Sharon Lutz/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 9-13-2006 Towson, Md. ₩i,lltop Service Co. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundal Service Litensee Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 23a. Part1. Enter the disease, or complications that oused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death DEMTHER PROVED BY MEDICAL EXAMINER Immediate Cause (Final disease or condition resulting in death) Priysician Traumentic severe /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any, loading to minimal decause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consiquence of) Be Completed by Physician/Medical Examiner physicien and s the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No ğ 4□Pregnant at time of death 5 Other (specify) signed by the e 9□ Unknown Part IJ. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown cate has been signated by page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed; 1 ☐ Yes 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending after death. 1 ☐ Yes 2 No 2-2006 1110 Fall 2 Accident investigation 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Fluksburg, MD 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

within 24 hours a To the Funeral C Hospitel Ped Ped

> State Registrar

S. Greene St 31. Date filed (Month, Day, Year) SEP 1 4 2006

29b. Signature and title of certifier

devard

(Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) But more
32. Registrary Sig 32. Registrar's Signatur

MD

29c. License number

29d. Date signed (Month, Day, Year)

		_	For State	State of Marylan		rtment of H			200	6 29234
			Registrar 1. Decedent's Name (First, Middle, Las.	0		incate or i	Journ	2. Date of Death		3. Time of Death
	Physicia	an	MERIVA	ROSE	MOR	GAN		SEPT. 1	0 2000	5:05 Pm
3	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	7707	1	Location of Death	4	c. County of Deat	h
		•	GILCHRIST	HOSPICE		L-	ALTIM	ORE	^	VA
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs.	10	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birt	hplace (State or Foreign untry)
	Director		122-68-1798	JM 2007	19 Yrs.			MARCH 12,1	1951 JA	MAICA
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits
	Many fed	ğ	MARIJAIN BAITI	MORE		PEDD	11 HAL	_		1 ☐ Yes 2 No
	r 28a	Director	10e. Street and Number	,,,,,,		10f. Zip Code	7	10g. (Citizen of What Co	untry?
	death with the Maryland ome 23a or 28a-f ehow ir neat be notified at		9703 PER	RU FARMS 1	DRIVE		21128	7	45,	9,
	deat	Funeral	11. Marital Status	12 Was Decedent Ever in U Armed Forces?	I.S. 13.	Vas Decedent of H	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
36	or It	J.	1 Never Married 2 Married	1 ☐ Yes 2 No		I Yes 2 No	Specify:		Specify: /2	1 0011
Maryland 21215-0036	72 hours after natural', or Ite	d by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:	16a Deces	lent's Usual Occup	ation	16h	Kind of Business	Industry
ή	n 72 n "nal	Completed	(Specify only highest grad	de completed)	(Give	kind of work done of NOT use retired	during most of work	ang	Trans or Desiriosa	inoustry
72	I within liene. r than "	Eo	Elementary/Secondary (0-12)	5 + (B.5)	OF	FICE .	MANAG	ER U	NIVER.	SITY
ğ	e filed within at Hygiene. I other than "	BeC	17. Father's Name (First, Middle, Last)	7. (e (First, Middle, Maid	en Sumame)	7
<u>la</u> r	should be ind Mental marked c	ToB	STANLEY	A.	GR	ANT	GLOF	315	- KGL	AKE
ary	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. Item 27 is marked other than "natural", or itema 23a or 28a-1 show other treumatic event, the Modical Examiner number to notified at		19a. Informant's Name/Relations p (7	ypa, Print)	19b. Mailin	g Address (Street	and Number or Rur	al Route Number, City	y or Town, State, 2	Zip Code)
-	1 and 2 Health tem 27 other tre	100	GILBERT H.E.M	ORGAN (HUSBANL	970	3 MERR	1 FARMS	DRIVE, FEI	RRY HALL,	MD 21128
ore	Pages 1 nent of H int: If Iter iny or oth		20a. Method of Disposition 1 ∠ Burial 2 □ Cremation 3 □		cemetery, cren	sition (Name of / natory or other plac	(8)		Lo tion - City or	
Ë	nit. Pag sertment ortant: injury c		4 □Donation 5 □ Other (Specify	De	ILANE	1 VALLEY	(EME 09-			MARYLAND
Baltimore	permit. Pages Depertment of I Important: If It eny injury or o		21. Signardia di Funeri I Service Licen)° (D)		Name and Addre	SS OF FACILITY BR	AVE, B	FUNER 9LTO, ML	PAL HOME
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that ceused the dea	th. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Breast	Canc	W				Onset and Death YEAVS
1	/Medical		resulting in death)	Due to (or as a consec						
п	Examiner		Sequentially list conditions,	b						
٨	be sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Die to (or as a consec	quanca-of):					
3.	be executed iicien and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consec	guence of):					
8760	cate be ex ohysicien the buria	dicai E								
687	ficate p physics the	edic		. 6.						
Box	The law requires that the death certificate ate has been signed by the attending physoge 2 should be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn		Ectopic pregnancy			23d. Date of de	ivery
	death	icla	in the past 12 months? 1 ☐ Yes 2 🗷 No	4 Pregnant at time of a		Other (specify)			Month	Day Year
P.0	at the de by the a tached	hys	9 Unknown	9LI ONKNOWN						
	res tha signed I be det	ρ	Part II. Other significant conditions of	ontributing to death but not re-	sulting in the u	nderlying cause giv	en in Part I.		Α.	the cause of death?
bic	w require been si should I	ted						1 Tes	2 ☐No 3 ☐ Pi	obably 4 Unknown
Vital Records,	law r	Completed						24a. Was an autopsy	prior to	topsy findings available completion of cause of
<u>~</u>		ပ်						performed 1 ☐ Yes 2 🗷		2 No
Vita	Physician: This certificatal director, p	Be	25. Was case referred to medical examiner?	Hospital:		at 30 pos Ott	00	th (Check only one)		10 0
o	S S	.T	1 ☐ Yes 2 🔀 No 27. Manner of Death	28a. Date of Injury	28b. Time o	11 30 DOX	4 Nursing Fi	ome 5 Residence		city) has peq
Division of	ding h. After fune	ţ	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	Wor	k? Yes 2 □ No		,,,	
İSİ	Atten deat ctor: y the	fica	3 Suicide 6 Could not be	28e. Place of Injury - At h	nome, farm, str			28f. Location (Street		ural Route Number,
á	ator, after t Dire	Certification:	4 Homicide	building, etc. (Spec	ify)			City or Town, St	a10)	
	To the Hospital or Attending Physicial 24 hours after death. To the Funerel Director: After the completely filled in by the funeral	Medical C		ysician: To the best of my kn niner: On the basis of examin and manner stated.						
	o the o the omple	Me	29b. Signature and title of certifier	0		29c. Licens	se number	29d.	Date signed (Mon	h, Day, Year)
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	1.0		30. Name and address of person who			Print)		0	4	1/ 2006 1204
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	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Sign	nature A	and I				
	Regist	rar	SEP 1 4 20	UD STEELS	~ //					

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No.? 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician 5:45 Marion Murphy 09/09/2006 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard 6388 Forest Ave. Elkridge If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2√□ F Yrs 213-20-9366 80 Director 11/21/1925 MD Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Martical Examinar in usit he natified at once. 1 Yes 2 No **Elkridge** MD Howard Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21075 6388 Forest Ave USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 录No Specify Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 9 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Marion Kelly William Basil Jr. 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6388 Forest Ave., Elkridge, MD 21075 Daughter Marion B. Murphy 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Park 09/13/2006 Elkridge, MD Gary L. Kaufman Funeral Home at MMP, INC. 7250 Washington Blvd., Elkridge, MD 21075 21. Signature of Funeral Service Licen M01378 23a Part Enter the disease, o coor shock, or heart failure. List only folications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death OPC Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. E. The Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Pox 68760,4 that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year 4 Pregnant at time of death 5 Other (specify) be detached Division of Vital Records, P.O. 9 Unknown 23e. Qid tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown Yes been sig 24a. Was an autopsy performed? 1 ☐ Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 certificate within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🔨 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 9-11-06 of death (Item 23a) (Type, Print)

State Registrar

1

DHMH 17 Rev 1/2001

32. Registrar's Signature

Dudge, MD

31. Date filed (Month, Day, Year)

Ritchie Huy but 134

Pasadena MO 21/22

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Jeffery Ryan Maddox 1- For State Certificate of Death Registrar

1. Decedent's Name (First, Middle, Last) Date of Death Physician/ 1826 hrs September 10, 2006 Medical Examiner JEFFREY RYAN MADDOX 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (if not institution, give street and number) Cecil Fikton Brick Hill Road at Route 213 8 Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** oreign Hours Director 1971 Pennsylvania Apr 16. 180-56-8460 1 X M 2 35 Usual Residence of Decedent 10d Inside City Limits 10c City, Town or Location 1 Yes 2 X No 28a-f show Douglassville notified at once. Berks County with the Mary land Director 10g. Citizen of What Country 10e. Street and Number 19518 **USA** 488 Old Philadelphia Pike 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 2 Married Never Married 2 X No Yes 4 X Divorced If Yes, Give Yea Yes 2 X No specify. White Widowed ģ 16a Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) marked other than c event, the Medical Construction Baltimore, MD 21215-0036 Carpenter 12 and Mental Hygiene 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Barbara R. Wade Alan M. Maddox 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဂ 90 Pages I and 2 sho ment of Health and ant: If item 27 is or other traumati 513 West Chestnut St., Pottstown, PA 19464 Barbara R, Maddox (Mother) 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State Department of Important: injury or other Tri County Crematory 9/16/2006 | Pottstown, PA Other Specify: 21. Signifure of uneral ferius licenses Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc. auson Martin D. Lawson 21212 Approximate Interval Baltimore, Maryland 23a Part I. Enter the disease, or complications that caused the death. Do not enter Physician Between Onset and failure. List only one cause on each line /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical AMENDED UNPENDED Box 68760 23d Date of delivery 23c If yes, outcome of pregnancy IF FEMALE. phy 23b Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, P.O. þ Yes 2 No 3 Probably 4 ✓ Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? . death? No ✓ Yes 2 Yes 26 Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: Other₄ Hospital 1 Inpatient 2 examiner? ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other Scene this 1 🗸 Yes 2 No 28a. Date of Injury FOUND: 28b. Time of Injury 28c. Injury at Work 28d. Describe how injury occurred 27. Manner of Death Subject motorcyclist in fixed object impact Certification FOUND: Natural ae Funeral Director: b Yes 2 🗸 No Pending Sep 10, 2006 1826 hrs 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) Brick Hill Road and Route 213, Elkton, MD determined (Specify) Local Street Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the one) and manner stated 29d Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c License number September 11, 2006 O.C.M.E Jn. 30. Name and address of person who complete 3 ause of death (Item 23a) 10 Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registrar 31 Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** John McCou 0207 peptember 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital Baltimore City If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 1 18 2 F Months 225-44-8525 70 Director Oct 9, 1935 N. C Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other then "nature!, or iteme 23s or 28s-1 show any njury or other traumatic event, the Medical Examiner must be notified at 2006. 1 Yes 2 No Baltimore Md Director NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21205 1400 E. Madison Strreet U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Xo Specify: If Yes, Give Year or Dates: Completed by Specify. Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Sanitation Elementary/Secondary (0-12) Sanitation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William McCoy Luella Joyner 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clara Jean McCoy Daughter 2030 E. North Avenue Baltimore, Md 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 2 Cremation 3 □Removal from State 1 Burial 09/07/06 Md **Bayview Crematory** 4 Donation 8 Other (Specify) 21. Signal 22. Name and Address of Facility Miller's Metropolitan Chapel P.C. 1639 North Broadway Baltimore, Maryland 21213 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Part 1. Enter the disc shock, of heart failu Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute respiratory distress syndrome 21 days /Medical Examiner 2 years Failure 10 thrive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month detached for Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐ Unknown 9 Unknown δ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe certificete 1 Yes 2 X No Director: After this certific I in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death 2 Accident 3 🗌 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Anu Gupta, Medical Doctor Res-000 September 1, 2006

State Registrar

marke

Anu Gupta, The Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore, Maryland 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

31. Date filed (Month, Day, Year)

SEP14

2. Registrar's Signature

		- For Amend item#12, pe Registrar 1. Decedent's Name (First, Middle, Last)		-		tificate of	Douth	2	Date of Deat	h No. Z	0.6	2923 3. Time of Death
Physiciar /Medica Examine	al -	4a. Facility Name (If not institution, give s 4 East 32nd Str	street and number)	LIAIII	. D. F.	4b. City, Town, Baltin	or Location of		Sept 1	1	y of Death	10:00P
Funeral Director	L			e (In yrs. 1 78	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24	Min.	Date of Birth (Month, Day,			place (State or Foreig htry)
fed at		Usual Residence of Decedent 10a. State 10b. County MD N/A			y, Town or Lo Balti						1	0d. Inside City Limit XXYes 2 □ N
23a or 28a	al Director	4 East 32nd Str	eet			10f. Zip Code 212	218		1	0g. Citizen of		ntry?
- 3	by Fur	11. Marital Status XXNever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 X Yes ZX If Yes, Give Year or Dates:			Was Decedent of f Yes, specify Cul		n? (Specif Puerto Ric	y Yes or No- an, etc.)		ice - Americ ack, White, ify: Wh	
giene. er than "natu	Completed	15. Decedent's Edu- (Specify only highest grade Elementary/Secondary (0-12) 1 2		5+)	(Give	dent's Usual Occu kind of work done DO NOT use retin YV1SOL	durina most o	of working		Socia		curity
and Mental Hygiene. ie marked other than sumatic event, the Ma	To Be (17. Father's Name (First, Middle, Last) William D. Me	riwethe	r, S			Phyl	lis	Rees			
ealth and m 27 ie m		19a. Informant's Name/Relationship (Ty. Jeanne Chapple			392	5 Beech	and Number Na Aven	ue	Apt 2	05 E	alto	<u> </u>
Department of Health a important: If item 27 is any injury or other tra		20a. Method of Disposition 1 □ Burial 2 XXX emation 3 □ R 4 □ Donation 5 □ Other (Specify)		- C	emetery, crer tro C	sition (Name of matory or other pl remato	. A		/06		svil	le,MD
Depart import any in		21. Signature of Funeral Service License	o pin	la	3 3	Name and Add urgee-1 631 Fa.	ass of Facility lenss – Is Ro	Seit	z Fun Balto	eral	H2me	i1 Inc.
hysician who priced and who priced was transit was transit with the priced win	Exa	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, teacing to limitediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequ	uence of):	er						30 de.ys
as been signed by the attending physicien and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1□Live birth 4□Pregnant at 9□ Unknown	2 Fetal	Ideath 3	Ectopic pregnand Other (specify)	-y			1	ate ol delive onth	ery Day Year
been signed b	≥∣	Part II. Other significant conditions cor	itributing to death b	ut not resi	ulting in the u	nderlying cause g	ven in Part I.			oacco use cor es 2 □ No		ne cause of death?
cete has been page 2 should	Completed								24a. Was all autops perform	y ned?	prior to con death?	psy findings availal mpletion of cause o 2□ No
s certificate director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	lospital: 1 ☐ Inpatie	ent 2 🗆	ER/Outpatier	nt 3□ DOA O			5 Reside	-/	her (Specifi	v)
fter t	ation;	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Inju (Month, Da	ry y Year)	28b. Time of Injury	W		280	f. Describe ho			
within 24 hours efter death. To the Funerel Director: A completely filled in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, et	c. (Specify	v) 	eet, lactory, office			City or Towr	i, State)		l Route Number,
Fune letely fi	edicai	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sician: To the best ner: On the basis of and manner st	f examina	wledge, death tion and/or in	n occurred at the vestigation, in my	ime, date and opinion, death	place, and occurred	I due to the ca at the time, da	ause(s) and mate and place	nanner as si , and due to	tated. the cause(s)
withir To th comp	Me	29b. Signature and title of certifier	etten, MD				se number			od. Date sign		Day, Year) 3, 2006
		1 : 47 1 1	mpleted cause of d							*		

		1 - For State Registrer		tate of Ma	ryland		rtment tificate			nd M		Reg. No.	2006	
/M	sician edical miner	FLORENC	E MU				4b. City, To	own, or L	ocation of	f Death	2. Date of De Month SENT	Day	11 2006 County of Deat	
Fune Direc		5. Social Security Number 218-26-43	6. Sex		MEDIC (In yrs. last		If Under 1	Year Days	If Under 2 Hours	OD R.C 24 Hrs. Min.	8. Date of Bi (Month, Di	ay, Year)	9. Birtl Co	hplace (State or Foreign untry) MD
Maryland	tor		County NA		10c. City, T	fown or Loc								10d. Inside City Limits 1 XYes 2 ☐ No
Z I Z I D-UUSD T within 72 hours after death with the Maryland jiene rithen "naturel; or items 23a or 28s-1 ehow	Funeral Director		☐ Married	Was Decedent E Armed Forces? 1 ☐ Yes 2 170 N		i	Vas Deceder Yes, specify	2122 nt of His y Cuban	panic Orig , Mexican,	gin? (Spe , Puerto F	cify Yes or No	0+	LIS. 14. Race - Ame Black, White	A nican Indian, e, etc.
TZT5-UU36 within 72 hours after ene. then "naturel; or ite	Completed by	Widowed 4 □D	ecedent's Educati y highest grade co	If Yes, Give Year or Dates: on mpleted) College (1-4or 5		16a. Deced (Give I life. D	Yes 25 ent's Usual (kind of work) OO NOT use	Occupat done du retired)	iring most	of workir	ng		Specify: B1 and of Business/	
be file	a B	Samuel Gee	2	na			omema		ROS	a Bo				
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Baitimore, permit. Pages 1 ar Department of Hea Important: if them	once.	4 Donation 5 C	Service Licensee	Right		Ma	Hill Name and rch E	Address H	of Facility West				ltimor	
Physici /Medic Examir	cal	23a. Parl. Enter the disc shuck, or heart failu mm. ate Cause (Final disease or condition resulting in death)	ease, or complicative. List only one can a	ohs that Jused ause on each lin	e.		er the mode	of dying.	such as o	cardiac o	r respiratory a	arrest,		21215 Approximate Interval Between Onset and Death
8 / 60, sate be executed shysicien end	dical Examination		b d	Due to (or as a										
the deeth certificate by the ettending ph	Physician/Mad	IF FEMALE: 23b. Was decedent pregint the past 12 month 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	iant	If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal de	eath 3	Ectopic pred Other (spec					2	23d. Date of del Month	ivery Day Year
- 2 B		Part II. Other significant							n in Part I.			tobacco u Yes 2[o the cause of death?
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Of VITA Physician: this certific		examiner? 1 1 X Yes 2 ☐ No	Hos	oital: 1 npatie	nt 2□EF	VOutpatien	t 3□ DOA	Othor			<i> Check only</i> ne 5 ☐ Res		6 □Other (Spe	cifv)
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DIVISIO to the Hospital or Attendition 24 hours effer death. The Funeral Director: A	Med in by	3 Suicide 6 4 Homicide	determined	28e. Place of Injubulding, etc							City or To	wn, State)	ural Route Number,
Hosp 24 house	pletely filled in	29a. Certifier 1 (Check only 2)	ertifying Physici Medical Examiner		examination									
To the cithin 2	duo	29b. Signature and title o	f certifier	_				License				29d. Dat	e signed (Mont	h, Day, Year)
11,		PULO	-elel k	a de	MD) 		olo	46			Sep	+ 12	2006
4		30. Name and address of		leted cause of d				2 C L	P	-11,	No ce	. Wr	212	10
	State	31. Date filed (Month, Da	y, Year)	32 Registra	ar's Signatur	re		- 91	, '	41-1	A 1613 C	1 1-1		, —
Re	gistra	SEP	1 4 2006	RECEIPERS	1	An	all!							

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		•	For State Registrar	State of M	arylan	d / Depa <i>Cei</i>	artmer rtifica	nt of Health ar		Re	eg. No.	106	29240)
	Physicia /Medic		1. Decedent's Name (First, Middle, Las. Eugene)		Mc	.cal	lum		Date of Deat Month	Day 3	Year 2006	3. Time of Death	
	Examin	er	4a. Facility Name (If not institution, give The Johns Hopkin	4 Hospit	al		Balt	Town, or Location of	Ly		4c. County NA			
	Funeral Director		5. Social Security Number 6. Se 212–60–9659 X	X 7. A ☐ 7. A	ge (In yrs. i 55	ast birthday) Yrs.	Months	r 1 Year If Under 24 Days Hours	Min. 8	Date of Birth (Month, Day, 7–19–1	Year)	9. Birthp Cour	Md.	_
	Maryland -f show lied al	tor	10a. State 10b. County Md. NA		10c. City	, Town or Lo		v				1	0d. Inside City Limits	
	h with the	ai Director	10e. Street and Number 1605 N. Bond Stre	et			10f. Zi	21213		1	0g. Citizen of USA	What Cour	ntry?	
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or frems 23a or 28a-f show aumatic event, the Medical Exartlar must be contilled at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Amed Forces 1 Yes 25 If Yes, Give Year or Dates:	? No		Was Dece If Yes, spe 1 - Yes	dent of Hispanic Origi orify Cuban, Mexican, 2 No Specify:	in? (Speci Puerto Ri	fy Yes or No- can, etc.)		ck, White,	can fndian, etc. Lack	
Baltimore, Maryland 21215-0036	vithin 72 hound. Ind. Ind. "nature In Medical E	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de <i>completed)</i> College (1-4or	5+)	(Give life.	kind of w	ual Occupation ork done during most ouse retired)	of working		16b. Kind of B		dustry ck & Sons	
land 2	id be filed v entat Hygie ked other t ic event, II	To Be Co	12th grade 17. Father's Name (First, Middle, Last) Jason	David			ıllum			First, Middle, i	Maiden Suman			
, Mary	permit. Pages 1 end 2 should be Department of Health and Menta Important: if item 27 is marked any injury or other traumatic es anca.		19a. Informant's Name/Relationship (7	ype, Print) Daught		9	Bail	ey Lane, O	wings	s Mills	, Md.	211	17	-57
timore	Pages 1 Iment of He tant: If Iten jury or oth		20a. Method of Disposition The Burial 2 Cremation 3 4 Donation 5 Other (Specify		• c	Place of Dispo emetery, crea odlawn	matory or Cem	etery	Dai 9–11-		20c. Location	•		
Bal	permit Depar Impor any in		21. Signature of Funeral Service Licen 21. Signature of Funeral Service Licen 22. Part 1. Enter the disease, or comp	War	ne_	2	1101	E. North	Ave.,	Balti			21202 Approximate	
	Physician /Medical Examiner		shock, or heart failure. List only in the shock of heart failure. List only in the shock of the	a. Seps	line. S a conseq	uence of):							Interval Between Onset and Death 12 hours 4 days	
8760,	death certificate be executed e attending physicien and for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Predir Due to (or a c. Acuiv Due to (or a	e a conseq	uanca off	Des	ciency Sino	drom	e			8 years	
P.O. Box 6	that the death certific ed by the attending p detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	Ideath 3[⊒Ectopic ⊒ Other (s	pregnancy		Ψ		ate of deliv	ery Day Year	
	Se us	ρ	Part II. Dther significant conditions o	ontributing to death	but not res	ulting in the u	underlying	cause given in Part I.		23e. Did to	V	tribute to t	he cause of death?	
Division of Vital Records,	The law ate has b page 2 sl	Completed								24a. Was a autop: perfor 1 Yes	sy med2	Were auto prior to co death? 1 Yes	opsy findings available impletion of cause of	
of Vita	Physician: Th this certiticate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 X No	Hospital: 1 XInpa		ER/Outpatie	nt 3 🗆 🛭	OCA Other: 4 Nur	sing Hom		ence 6 🗆 Otl	, -,	fy)	
sion o	al or Attending P s after death. I Director: After t id in by the funera	Certification:	27. Manper of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			28b. Time of Injury	М	28c. Injury at Work? 1 Yes 2 N	lo		ow injury occur		al Route Number,	
Divi	lospital or Al I hours after of uneral Direction by		4 Homicide determined	1	etc. (Specil	(y)		d at the time, date and		City or Tow	n, State)			
	To the Hospital within 24 hours of Forthe Funeral I completely filled	Medical	(Check only 2 Medical Example)	niner: On the basis and manner	of examina stated.	ation and/or in	nvestigatio	on, in my opinion, death	h occurred	d at the time, o	date and place,	, and due t	o the cause(s)	_
	S S S		30. Name and address of person who Andrew Kqu, The	, Medica	al D	octor	•	Res-O	00		Septem	ber	3,2006	
= 0	4		30. Name and address of person who Andrew Kqu, The	completed cause of Tohns Ho	death (Iter	n 23a) (Type Hospita	, Print)	D North Wo	Ife :	Street	Baltin	ure.	Jaryland Varyland	
2.	St	ate		006 32. Re gi	strar's Sign	ature /	Joseph .	6					4	

State of Maryland / Department of Health and Mental Hygiene For Stete Registrar 1-Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 18 chael September 2006 10 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore N/A Johns Hopkins Hospital 8. Date of Birth (Month, Day, Year) Aug. 20, 1962 Year If Under 24 Hrs Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) **Funeral** Days Months Hours Min. 1 M 2 □ F Yrs. 44 Director 215-76-1973 Maryland Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Dundalk Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21222 238 1913 Dineen Drive Funerai death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) tems 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 ☐ No Specify: Spacify: White ģ 3 ☐ Widowed 4 ☑ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Roofing Roofer 11 Years 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be s 1 end 2 should be fi f Health and Mental H item 27 is marked of Ann Collier Charles G. Miller ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Charles Miller (Father) Dundalk, Maryland 1926 Armco Way item 27 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1
Department of H
Importent: if ite
any injury or ot 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 9/15/2006 Towson, Maryland Hilltop Service Corp. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licensee 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 6 days vancea Hemorrhage disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner irrhosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury equence of) Examine or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events ed by the attending physiclen and detached for use as the burial-tra resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown cate has been signed to page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has 1 ☐ Yes After this certification, funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient Certification; To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending efter death. 1 🗌 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours e To the Funerel C Hospitei Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 9 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 September 10 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) n Marisha Cook, The Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore, Mayland 21287
31. Date filed (Month, Day, Year) 32. Registrar's Signapore 32. Registrar's Signature State 2006 Registrar

			For State Registrar	State of Maryland	/ Department of Health and N Certificate of Death	lental Hygier Reg. ۱		29242
I	Physici	an	1. Decedent's Name (First, Middle, Last,	Oram		2. Date of Death Month)ay Yeer 10 2006	3. Time of Death
>	/Medic Examin		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death	September	c. County of Death	1
	Funeral		5. Social Security Number 6. Sec	emorial x, 7. Age (Inyrs. Iqst	birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea	9. Birthpla	ace (State or Foreign
	Director		212-38-4344 1) Usual Residence of Decedent	M 2 F 64	Yrs. Months Days Hours Min.	4-1)-10	742 Counti	"(M))
	show	'n	10a. State 10b. County	10c. City, T	ome or Location	2	10	d. Inside City Limits
	th the M or 28e-f	Director	10e. Street and Number	1-	10f. Zip Code	10g. (Citizen of What Count	ry?
	death wi	Funeral D	2174 Pen 1 11. Marital Status	Land Dir 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - America	
36	should be filed within 72 hours after death with the Maryland and Mental Hygiene. s marked other than "netural", or Items 23s or 28e-f show numatic event, the Modical Exertified at	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, e	tc.
21215-0036	72 hour	eted	15. Decedent's Edu (Specify only highest grad	cation 1	6a. Decedent's Usual Occupation (Give kind of work done during most of work	sing 16b.	Kind of Business/Inde	ıstry
2121	d within giene. er than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	SUPERVISOR	IV	1echan	CAL
Maryland	d be file ental Hy ced oth	To Be (17. Father's Name (First, Middle, Last)	Oram	18. Mother's Nam	e (First, Middle, Maid	en Sumame) &S	
lary		<u>; </u>	19a. Informant's Name/Relationship (T)	1 . 1 / .	19b. Mailing Address (Street and Number or Rur	al Route Number, City		Code)
	s 1 and 2 f Health Item 27		20a. Method of Disposition	20b. Place	2179 Pattand Dr e of Disposition (Name of etery, crematory or other place)	Date 20c.	Location - City or Tow	vn, State
Baltimore,	permit. Pages Department of Important; If It any injury or o		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	removal from State	ny Memorial 91	5 a	Co dibility	dun (W)
Ba	permit. Departi Import any inj		21. Signature of Funeral Service Licens	Howell L	22. Name and Address of Facility	H. Baer	Threwe 1	10m2
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line.	Do not enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a compuen	ice of):			2 hours
	Examiner	ler	Sequentially list conditions, if any, leading to immediate	b. Massive M	Nyocardial Infarc	tion	- 4	3 hours
	cate be executed physician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Coron ary	Artery Disease		>	10 years
	E 20	ш		,				•
3760	ate be hysici he bu	icai		i.				
ox 68760,	n certificate be inding physici use as the bu	n/Medical	IF FEMALE: 23b. Was decedent pregnant	d. 23c. If yes, outcome of pregnancy			23d. Date of deliver	y
Box 6	ne death certificate be the attending physici	cian/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	d. 23c. If yes, outcome of pregnancy 1	ath 3 Ectopic pregnancy			y Day Year
s, P.O. Box 6	es that the death certificate be gned by the attending physici be detached for use as the bu	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 □Ectopic pregnancy h 5 □ Other (<i>specify</i>)		Month E	Day Year cause of death?
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Records, P.O. Box 6	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 □Ectopic pregnancy h 5 □ Other (<i>specify</i>)		Month Duse contribute to the 2 □ No 3 ☑ Proba 24b. Were autop: prior to comdeath?	Day Year cause of death?
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			State of Maryland / Departmer State of Maryland / Departmer Certificat	nt of Health and Me te of Death	ental Hygie Reg	ene 2006	29243
Ph	ysicia		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
//	Medic	al .	THOMAS CLAYTON PHILLIPS 4a. Facility Name (If not institution, give street and number) 4b. City,	, Town, or Location of Death	ETEMBI	62 II 200 4c. County of Deat	3
Ex	amine	45	ALTIMORE WASHINGTON MEDICAL CENTER	GUEN BURNI	P	ANNE	A Penader
Fun Dire	eral ctor			or 1 Year If Under 24 Hrs. 8	B. Date of Birth (Month, Day, Y May 16,1	(ear) 9. Birt (Co L949 Wa.s	hplace (State or Foreign suntry) shington
and w			Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
the Marylan 28e-f ehow	fied a	ţŏ	Maryland Anne Arundel Pasadena				1 □ Yes 2 No
th with the	list be not	al Direc	10e. Street and Number 350 Green Mountain Court	p Code 21122	10g	U.S.A.	untry?
1215-0036 in the Maryland and and Table 1999 and and and the maryland and then "natural", or Items 23a or 28e-7 ehow	saminer must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Sive 1 Yes of Sive Year or Dates:	edent of Hispanic Origin? (Speci ecify Cuban, Mexican, Puerto Ri 2 No Specify:	fy Yes or No- ican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
215-00 bin 72 hou	the Madical Ex	Completed	15. Decedent's Education 16a. Decedent's Usu	ual Occupation ork done during most of working use retired)	7	6b. Kind of Business/	Industry
nd 212	in the		12 0 Meat Ma				ood Market
	event,	Be	17. Father's Name (First, Middle, Last) Thorney Phillips	18. Mother's Name (First, Middle, Ma reenwood		
	umatic	၉		s (Street and Number or Rural I			Zip Code)
% ≥ 5 € %	ŧ	100		en Mountain Cou		adena, Mar	yland 21122
	or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Na cemetery, crematory or a Bayview Crematory)	other place)		c. Location - City or $altimore$,	
Baltimore,	eny injury or c pnce.		21. Signature of Euneral Service Licenses 22. Name a	ind Address of Facility Ly-Polyniak Fun Mountain Road,	-		
<u> </u>	• 4		23a art1. Enter the disease, or complications that caused the death. Do not enter the mo				nd 21122 Approximate
Physic	cian		shock, or heart lailure. List only one cause on each line.		, ,		Interval Between Onset and Death
/Med Exam	lical		resulting in death) a. Due to (or as a consequence of):	UBZY OF	-	51771	
LAdiii		5	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence ol):	URY OF	4G1M.		
A B	ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
68760, difficate be executed and and	burial-transit	al Exa	resulting in death) Last Due to (or as a consequence of):				
cate	the	ledical	d				
Division of Vital Records, P.O. Box 6 To the Hospitel or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending	be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic parts at time of death 5 ☐ Other (step 1) ☐ Other (step 2) ☐ Unknown			23d. Date of deli Month	ivery Day Year
rds, P. (puires that the property of signed by			Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I.	23e. Did tobad		the cause of death?
Division of Vital Records, to Attending Physician: The law requires the placetor. After this certificate has been signe	page 2 should	Completed			24a. Was an autopsy performe	prior to death?	itopsy lindings available completion of cause of
Vital F dci a n: Th	octor	Be	25. Was case referred to medical examiner?	26. Place of Death (
Of Of Physic	= =	2	1 ☐ Yes 2 ☑ No Hospital: 1 _ npatient 2 ☐ ER/Outpatient 3 ☐ D 27. Manny of Death 28a. Date of Injury 28b. Time of		e 5 Residence	ce 6 ☐Other (Special	cify)
ion Ion Inding	e funeral	atlon	1 Vatural 5 Pending (Month, Day Year) Injury 2 Accident investigation M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	id. Booding non	injury occurred	
DIVIS el or Atte s after de:	ed in by th	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, larm, street, factor building, etc. (Specify)	y, office 28	Bl. Location (Stree City or Town, S	et and Number or Ru State)	ıral Route Number,
DIVISIO To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A	completely filled in by the	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred the best of examination and/or investigation and manner stated.	I at the time, date and place, an n, in my opinion, death occurred	nd due to the caus d at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
To the within To the	Com	₹	29b. Signature and title of certifier W. D. W.	DC. License number	290	I. Date signed (Monti	1, Day, Year)
153	rl	4	and address of perso, who completed cause of death (Item 23a) (Type, Print)	glen Br	unue	Mid	1000
, Re	Stat egistra		31. Date liled (Month, Day, Year) SEP 1 4 2006	le			

			For State Registrar		State of	of Maryla		epartme Certifica				lental Hy	gien Reg. N	200	6	29244
			Decedent's Name	(First, Middle, I	.ast)							2. Date of D	eath			3. Time of Death
	Physici /Medio		Doris		Jane		Palme	r				SEPTE	MBE	20 11 20	06	7.50P M
	Examin		4a. Facility Name (II	f not institution, g	ive street and nu	ımber)	0		ty, Town, o		of Death		4	c. County of De	ath	2
			BARTIMORE	2 WASHIN	ugton 1	ESILH	LEN	1762	CIE	A 4	or 24 Hrs.	_		PINE	7/4	TUNDEL
	Funeral Director		5. Social Security N 232-26-69	umber	Sex 1 □ M 2 ☐ F	7. Age (III yrs	s. last birthi 6 Yi	Month	der 1 Year s Days	Hours		8. Date of Bi (Month, D Jan	rth ay, Yeai 3 19	20 9. 8	Sirthpla Countr	ce (State or Foreign y) WV
			Usual Residence of									our	,,,,	20		
	ryland how		10a. State	10b. County			City, Town								100	d. fnside City Limits
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	with th	Director	10e. Street and Nur						Zip Code					itizen of What	Countr	y?
	death with the Maryland ma 23a or 28a-f ehow I maat be notified at	Funeral	1210 Ove:	rview Dr		cedent Ever in t	118		1122	lienanic O	rigin? (Sp	acifu Vas or N	U.S	. A .	narica	n Indian
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036	ours after death with the Manylan ei', or items 23a or 28s-1 ehow Examiner must be notified at	ρ	3 🔀 Widowed		If Yes, G Year or (ive Dates:		1 ☐ Yes	2 ⊠ No	Specify	y:			Specify:	Wh	nite
50	72 hours after dea "naturei", or itema	Completed	(Spec	15. Decedent's	Education grade completed))	(ecedent's Us	work done	durina mo	st of work	ing	16b.	Kind of Busine:	ss/Indu	stry
$\frac{5}{2}$	vithin hen.	mpl	Efementary/Seco			(1-4or 5+)		ife. DO NOT .t Cuti	use retired	d)				45 D. C-		
4 2 B	filed v Hygie other I	ပိ	17. Father's Name	First, Middle, La	st)		nea	L Cul	Lei	18. Moth	ner's Name	e (First, Middle	. Maide	A&P Gr	OCE	ery
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Z	and 2 salth a n 27 io	l	Mrs. Jane	e Wendli	.ng /Dau	ghter	121	0 Ove	rview	Driv	ve Pa	sadena,	Ma	ryland	211	.22
$\frac{\partial a}{mer}$ Baltimore, Maryland	- £ 5 5		20a. Method of Disp		☐Removal from		Place of D cemetery,	isposition (A crematory o	lame of r other plac	ce)	Sept.	Date 15.	20c. l	Location - City	or Tow	n, State
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Salt	permit. Deperti Importa any inf		21. Signature of Fu	neraf Service Lic	ensee	1 11								neral H		
	40240		220 Part Short	k pli	anene_									Le, MD		61 Approximate
			23a. Part1. Enter the shock, or nea Immediate Cause (1		-			irrest,		1	nterval Between Onset and Death
100	Physician /Medical		disease or condition resulting in death)	n		(or as a conse			10 C	MM	JOEF				ļ	
	Examiner				040 10	(OI as a COIISe	aquerice or,									
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	acuted Ind transi	Examiner	Cause (Disease or that initiated events	injury	c											
50,	vate be executed only sicien and the burial-transit		resulting in death) t	Last	Due to	(or as a conse	equence of	:								
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9 x 6	ath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent	orognost	23c. If yes, ou	itcome of pregr	nancy							23d. Date of o	leliven	,
Box	death a atter d for u	Iclar	in the past 12	months?	4☐Preg	birth 2 ☐ Fet nant at time of		3 ☐Ectopic 5 ☐ Other		<i>'</i>				Month	-	ay Year
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S,	es tha igned be del	by P	Part If. Other signif	icant conditions	contributing to c	feath but not re	esulting in t	ne underlying	g cause giv	en in Part	I.	23e. Did	tobacco	use contribute	to the	cause of death?
pre	w require been si should t	Completed										1 🗆	Yes 2	2 No 3	Probab	ofy 4 🖭 Onknown
ec	elawr hasby ge 2 sh	nple										24a. Was	an psy ormed?	24b. Were prior t	autops o comp	sy findings available of cause of
Division of Vital Records, P.O.	Physician: The lathis certificete har all director, page				,							perf 1 ☐ Yes		o death	9s 2	□ No
Zi:	ician: Th certificete rector, pag	Be	25. Was case reference examiner?	/	Hospitaf:	/			Oth			(Check only			- 8	
ō	Phys r this oral di	.: To	1 ☐ Yes 2 ☑ 27. Manner of Deat		162	Inpatient 2 [of Injury oth, Day Year)	☐ ER/Outp 28b. Tin		DOA 28c. Injur			me 5 Res 28d. Describe		6 □Other (S)	oecify)	
lon	nding F ith. :: After s funeri	Certification:	1 Naturaf 2 ☐ Accident	5 Pending investigat		nth, Day Year)	Inji		Wor	k? Yes 2[,		
V.S.	or Attendi after death. Director: A in by the fu	HC	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	289. Plac	e of Injury - At I	home, farn	, street, fact	ory, office			28f. Location	Street a	and Number or	Rural I	Route Number,
ā	tai or rs afte ei Dir	Cert			Dulic	mig, etc. (Spec	JII 97					Ony or 10	wn, ota			
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funerel Director: After this certificete has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one)	1 Certifying 2 Medical Ex	Physician: To th aminer: On the t	pasis of examin	nowledge, and/	death occurre or investigati	ed at the tir	ne, date a pinion, de	and place, eath occurr	and due to the ed at the time.	cause(date ar	s) and manner nd place, and d	as stat	ed. he cause(s)
	within 2 To the	Med	29b. Signature and	tine of certifier	and mar	nner stated.		2	29c. Licens	e number			29d. D	ate signed (Mo	nth. Da	av. Year)
	ل ≒ ≨ ت			S	Say		YU	O	5	+((
	14		30. Name and add	s of person wh	o completed cau	se of death (fte	em 23a) (T	/pe, Print)	1	2 6						11 2006
			BNADS	10	301 H	orbite	al e	Tric	e	The	in le	unsalu	2 7	MI)	210	061
	Sta		31. Date filed (Mon.	_	32	Registrar's Sign	nature	back)						
	Registr	ar	S	EP 1 4 2	006	THE P	1 Sep									

06-06823 Wendy Rushing

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

	9	1- For State Registrar		•	icate of L				Reg No	2006	2924
Physic Medical Exam		Decedent's Name (First, Middle Wendy Mary Rus	•			-		2 Date of De Month Septemb		Year	3. Time of Death 0352 hrs
		4a Facility Name (if not institution			4b	. City, Town, or L	ocation of E			County of Death	
		6501 Kenwood Drive				Salisbury			W	icomico	
Funeral		5. Social Security Number	6. Sex 7. Age	(In yrs. last b	oirthday)	If Under 1 Year	If Under 2		Birth (MM/D	D/YYYY) 9. Birth	
Director		212-78-7214 Usual Residence of Decedent	1 M 2XF	40	Yrs	Months Days	Hours	JAN	29, 1	.966 Foreign	^{ntry)} Canada
vlaryland 28a-f show auy d at once.		10a. State 10b. County		10c. City, Tow	vn or Location	n					10d Inside City Limits
fand f sho	ğ	MD Wicomi	co	Salis							1 Yes 2 X No
Mary r 28a- ed at	Director	10e. Street and Number				10f Zip Code			10g Citize	en of What Count	ry?
r with the Maryland ms 23a or 28a-f sho be notified at once.	O E	724 Hemlock St	I 40 Was Davidson	11.0	140.18/	21804		2 / O	USA		L.E. Disale
72 hours after death with the Maryland n"natural", or items 23a or 28a-f she al Esaminer must be nofifted at once	Funeral	11. Marital Status 1 Never Married 2 Mar	12. Was Decedent 6 Armed Forces?			Decedent of Hisp s, specify Cuban,		? (Specify Yes or Nuerto Rican, etc)	10-	4. Race - Americ White, etc	an Indian, Black,
fter d		3 Widowed 4 Divo	1 Yes 2	X No	1 \ \	res 2 X No	specify.		5	Specify:Ameri	can Indian
ours a atura	d by	15. Decedent's Education (Spec	ify only highest grade com	pleted) 16a		Usual Decupation				nd of Business/In	
5-0036 ed within 72 hours at tygiene other than "natural other than Battaral	Completed	Elementary/Secondary (0-12)	College (1-4 or 5			st of working life. I	DO NOT US	e retired)			
5-0036 led within 72 Hygiene other than	Juc	12 17. Father's Name (First, Middle, I	l anti		Homema		O Mathada N	Name (First, Middle		n Home	
		Edmond Delaney	Last)			1	UNK	vame (First, Middle	, Maiden a	зиттапте)	
21215 should be file and Mental H is marked of	To B	19a Informant's Name/Relationsh	ip (Type, Print)	1	19b. Mailing A			r or Rural Route N	umber, City	y or Town, State,	Zıp Code)
O g B in in	-	David Rushing/H	J usband		724 He	mlock St	Sali	sbury, M	218	04	
ore, ML es 1 and 2 s of Health a If item 27		20a Method of Disposition		20b. Plac		on (Name of cem-		Date		ocation - City or T	own, State
MOP Pages ent of nt: If		1 Burial 2 X Cremation 4 Donation 5 Dther Spe		ie.		atory, I	nc.	9/13/06	Ra	ltimore,	MD
Baltimore, permit Pages 1 at Department of He Important: If ite injury or other tr	1	21 Signature of Funeral Service L	icensee . O	Tring				ty of Man			110
ii ii De œ	1 1	C. Cold			29	9 Freder	ick R	d Baltimo	ore.	MD 21228	
Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause of	mulication that caused to each line.	the death Do	not enter the	mode of dying, s	uch as card	liac or respiratory a	rrest, shoo	ck, or heart	Approximate Interval Between Onset and
xamine		Immediate Cause (Final disease	a. Narcotic		ation						Death
		or condition resulting in death)	Due to (or as a conse	quence of).							
	jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	quence of).							
	Examiner	cause Enter Underlying Cause (Disease or injury that initiated	c. Due to (or as a conse	guence of)							
cuted ind transit		events resulting in death) Last	d	quence or).							
e exe cian a	1 3	X UNPENDED		m#23a,PI	I,27,28	a-f,perME,	g859,9	/18/06 TT		-	
Box 68760, death certificate be eithe attending physician do for use as the burial		IF FEMALE:	23c. If yes, outcom			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				Date of delivery	
Ox 68. ath certifi attending or use as	ian	past 12 months?	1 Live birth 2 Pregnant at t	time of death		death 3	Ectopic pr	regnancy		Month Da	y Year
30X death e atte	8	1 Yes 2 No 9 ✔ Unki	, , ,		5 Othe	er (Specify)					
O. B. Charthe de the deby the detached is		Part II. Other significant condition	ons contributing to death	but not result	ting in the un	derlying cause gr	ven in Part I	23e. Did	tobacco u	se contribute to th	ne cause of death?
P.O. rres that the signed by the detact	d b	Ocaine use						1Y	es 2	No 3 Proba	bly 4 🗸 Unknown
Division of Vital Records, tal or Attending Physician: The law required as after death. The The That this certificate has been simplified in by the funeral director, page 2 should be the time of the thing the time of time of the time of the time of time of the time of the time of the time of the time of the time of time of the time of time of time of the time of time of time of time of the time of time	Completed by							24a Wa	s an opsy		opsy findings available mpletion of cause of
eco ne faw te has	E						-		formed?	death?	1
tal Recision: The certificate	0	25. Was case referred to medical				26.Place	of Death (C	neck only one)			
Vita nysicia this cel	o Be	examiner? 1 ✓ Yes 2 No	Hospital. 1 Inpatier	nt 2 ER	/Outpatient	3 DOA	Other ₄ N	lursing Home 5	Residen	nce 6 🗸 Other	Scene
Jof Jing Ph After t funeral	l :	27. Manner of Death	28a Date of Injur (Month, Day, Ye	ry 28i ear)	b. Time of Inj	.		28d Describ	e how injur	y occurred	
Sion Attendi	atio	1 Natural 5 Pendi 2 Accident Inves	rigation Fnd 9/10/2	2006 un	ık	1 Ye	es 2 X N	° unk			
ivis or Al after of Direct	Certification:	3 Suicide 6 X Could	I not be 28e Place of Inj	_		, factory, office bu	ilding, etc				al Route Number, City
Div spital on nours al	Ce	4 Homicide		found in						5501 Kenwoo	
he Ho in 24 f he Fu.	ical		ysician: To the best of my niner:On the basis of exan								
To the within To the To the	Medical	29b. Signature and title of certifier	and manner stated			29c. License				ate signed (Mont	
- Jus	-	(01,00	10001	00.		O.C.N			1 _	ember 10, 20	
103		30 Name and address of person	who completed source of de	path (Itom 22)	al		_				
V		'	who completed cause of di sistant Medical Exan			treet, Baltimo	re, MD 2	1201			
<u> </u>	State		4 2006 ^{32 Registrar}		1. An	relis					
Regi		9EL T	4 2000	والمحمد المصارية	1						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 29246 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Thomas Rosser 1:03 AM Earl 13**,** 2006 September /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2 Wyndhurst Ave., Apt. 1A Baltimore N/A5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday. 8. Date of Birth (Month, Day, Year)
July 30, 1911

9. Birthplace (State or Fo. Country)
Pennsylvania Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1**X**M 2□F Director 212-03-4844 95 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23e or 28a-f show Examiner must be notified at 1 ☑ Yes 2 ☐ No Director Maryland N/ABaltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2 Wyndhurst Ave., Apt. 1A 21210 United States Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (X) Yes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Attorney Legal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Henry E. Rosser Minnie Hays Noble 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruxton, MD 21204 Christie R. Moseley/daughter 1503 LaBelle Ave. 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: if ita any injury or ot once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Greenmount crematory | Sep. 23,2006 Baltimore, Maryland 21. Signature of Funeral Service Licenșee 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, 6500 York Rd. Baltimore, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, skock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of). Examiner Cardies cni Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed aronan Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) the à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig , page 2 should b 2 No 3 Probably 4 □Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 2 No To the Hospital or Attanding Physician: After this certification Be 25. Was case referred to medical 26. Place of Death Check onl one examiner? 2 NO Hospital: Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) ٩ 1 Yes 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No hours after death. investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 - Homicide within 24 hours at To the Funaral D completely filled i Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 40048 war 2006 13 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7505 BUERSONA OSCERDR DAYID mD TOWSON 32. Regiana's Signature 31. Date filed (Month, Day, Year) State 2006 Registrar

				Plea 1. For State	State of M	int in Blac Maryland / [l Copies lental Hy	giene 2006	5 29247
				Registrar			Certificat	te of	Death		Reg. No.	
	ı	Physici /Media		1. Decedent's Name (First, Middle Walter	H. Rosko					2. Date of De. Month Septem	Day Year	
•	A.	Examir	ner	4a. Facility Name (If not institution			4b. City,	Town, o	or Location of Death	,	4c. County of Dea	
			4	Upper Chesapea 5. Social Security Number		Center Age (In yrs. last bir		elai r1Year	Lr If Under 24 Hrs.	8. Date of Birt	Harfor	
		Funeral Director		210-09-0523 Usual Residence of Decedent	1 X M 2 ☐ F	88	Months		Hours Min.	(Month, Da	y, Year) 10, 1918 B	rthplace (State or Foreign ountry) altimore, MD
		yland		10a. State 10b. County		10c. City, Tow	n or Location	,				10d. Inside City Limits
		ith with the Marylan 23a or 28a-f show	rector	MD Ba1 10e. Street and Number	timore	Phoe		o Code			10g. Citizen of What C	1 ☐ Yes 2 💆 No
3		h with	<u></u>	49 Club View L	ane			21	.131		USA	
loc		deat	ner	11. Marital Status	12. Was Deceden	nt Ever in U.S.	13. Was Dece		Hispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No		
1,	215-0036	within 72 hours after death with the Maryland ene. then "naturel", or Items 23e or 28e-f show he Middleal Exeminar must 2e notified at	Be Completed by Funeral Director	1 ☐ Never Married 2 ☐ Mar 3 📉 Widowed 4 ☐ Divorced	ried 1 1 Yes 2 1 If Yes, Give Year or Dates	1No 43'-45'	1 ☐ Yes		Specify:	1110415, 610.7	Black, Whi	
	5-0	72 hc	eted	15. Deceder	nt's Education est grade completed)	16a.	Decedent's Usu (Give kind of wo	al Occup	oation during most of worki	na	16b. Kind of Business	/Industry
	2	Aithin ne. ne.	mpie	Elementary/Secondary (0-12)	College (1-4or	r 5+) Sur	iife. DO NOT u perinten	d of	during most of working Rolling	Mill	G. 1 W	
P	121	D D =	ပိ	17. Father's Name (First, Middle,	(act)	Arī	nco Stee	1 Co	prp.		Steel Manu	facturing
Q	anc	ld be filed ental Hyg ked othe ic event,	Be		oskott					A. Foar		
9/0/016	Maryland	s 1 and 2 should be filed v Health and Mental Hygie tem 27 is marked other t	၉	19a. Informant's Name/Relations		19b	. Mailing Address	s (Street			er, City or Town, State,	Zip Code)
3	<u>s</u>	and 2 sealth ar n 27 ls		Carl Roskott/S			Club V				D 21131	2.5 0020)
0	ē,			20a. Method of Disposition		20b. Place of	Disposition (Na.	me of	1 0	ate	20c. Location - City of	Town, State
	Baltimore,	t. Peg rtment rtant: I		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	Specify)	⁰ Dulane Memori	y Valle al Gard	y ens	Sept.	6	Timonium	
	Ba	permi Depa Impo eny ir		100		T Floale	Lemmon	Fun	eral Home	of Dul	aney Valle	y, Inc.
				23a. Part1. Enter the disease, o	r complications that cause	ed the death. Do					m, MD 2109 rest,	Approximate
		Physician		shock, or heart failure. List Immediate Cause (Final			D:	0	-dio visia	0. (D	Interval Between Onset and Death
	7	/Medical		disease or condition resulting in death)		is a consequence		Car	-01107650		JURIOSE	yeers
7		Examiner		Parameter Karaman Milan								
40450	13/	D ≓	ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	is a consequence	of):					
The state of the s	10	e be executed sicien and a burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.		-4)					
60	60,	cien (al E	Todaking in dealiny code	Due to (or a	is a consequence	or):					
1	687	physic the t			d.							
17	ox 6	ding	/We	IF FEMALE:	23c. If yes, outcom	e of pregnancy	95000 rl				004 Data -644	16
Ma	O. Bo	Attending Physicien: The law requires that the death certificate ir death. •ctor: Atter this certificate has been signed by the attending physis by the funeral director, page 2 should be detached for use as the thing the true of the control of t	by Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1☐Live birth	2 Fetal death at time of death	3 ⊟Ectopic p 5 ☐ Other (s _f		у		23d. Date of de Month	Day Year
S	σ.	that the hold by a detact	y P	Part II. Other significant conditi	ons contributing to death	but not resulting in	the underlying	cause giv	en in Part I.	23e. Did to	obacco use contribute t	o the cause of death?
2	rds,	quires I n signe		Corona	y Arten	y des	ease			1 🗆 Y	/es 2 No 3 □ P	robably 4 Dunknown
	Vital Record	aw requir is been si 2 should	Completed	6	1					24a. Was	an 24b. Were a	utopsy findings available
	æ	The ta ate ha	E								prior to death?	utopsy findings available completion of cause of
	ita	iician: Th certificate rector, pag	Bec	25. Was case referred to medica	1				26. Place of Death	1 Yes		s 2 No
9		ysician: iis certific director,	To E	examiner? 1 ☐ Yes — 2 🌠 No	Hospital: 1 🔼 Inpai	tient 2 ER/Ou	tpatient 3 D	OA Oth	105		dence 6 Other (Spe	ecify)
5369	ion of	Attending Ph death. ctor: After th y the funeral		27. Manner of Death 1			Time of aniury M	28c. Injur Wor 1 🔲	ryat rk? Yes 2∐No	28d. Describe h	now injury occurred	
150	Division	or Attendest efter death Director:	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 288. Place of I	njury - At home, fa etc. (Specify)	rm, street, factor	y, office		28f. Location (S City or Tou	Street and Number or R vn, State)	ural Route Number,
7)		To the Hospital or Atte within 24 hours efter de To the Funeral Directo completely filled in by th	Medical C	29a. Certifier 1 Certifyii (Check only one) 1 Medical	ng Physician: To the bes Examiner: On the basis and manner s	of examination an	a, death occurred d/or investigation	at the tir	me, date and place, a opinion, death occurre	and due to the o	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
_		To the	Me	29b. Signature and title of certifie			29	c. Licens	se number		29d. Date signed (Mon	
		- >F 0		1 the	19			000	56607		September	6 th 2006
		1541	1	30. Name and address of person							/	6#2006
		12,		JOSEPH ANGE	20 # 20	5. 602	. S A7	WOO	DRd 1	SELM	no mo	21314
		Sta		31. Date filed (Month, Day, Year,	32. Regis	trar's Signature	arte					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 10:31 P™ September 8, 2006 Roche Nancy /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 6506 Montrose Avenue Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□ M 2X F Days Hours Yrs. New York Director 337-34-6560 64 14,1941 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, the Madical Examiner must be notified at ↑ Yes 2 No Director Baltimore Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 6506 Montrose Avenue 21212 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Cultural Arts Civic Arts Leader 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ၉ Albert В. Keen Kathryn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George A. Roche Husband Baltimore, Maryland 21212 if Item 27 6506 Montrose Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of important: if eny injury or once, 4 ☐Donation 5 ☐ Other (Specify) Druid Ridge Cemetery | 9-13-2006 Pikesville, Maryland 21. Signature of Auneral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Stage **Physician** breast cancer years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physicien and the for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Dav Year 4 Pregnant at time of death 5 Other (specify) s been signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy performed? Yes 2 No this certificate 1 Yes Hospital or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home Sesidence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA nerei Director: After th filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 27 Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number September 9, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Presiden Desai ati 32. F State 2006 4 Registrar

"natural", or tlems 23a or 28a-1 ehow Medical Examiner must be notified at Entered Director Medical by Funeral Director		213-48-2229 Usual Residence of Decedent 10a. State 10b. County Md. NA	Eliza re street and number) e Street Sex 7. Age		Radcliffe 4b. City, Town, or Location of Dec	2. Date of De Month 9	Day Year 5 2006	2:45am
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lical Examiner must be	2	10e. Street and Number			10f. Zip Code		10g. Citizen of What (Country?
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lical Exp	Laine	11. Marital Status 1 XNever Married 2 Married	12. Was Decedent Ev Armed Forces? 1 Yes 2 No ff Yes, Give		Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ☑ No Specify:	(Specify Yes or No arto Rican, etc.)	14. Race - An Black, Wh Specify:	
5 9 4		3 Widowed 4 Divorced	Year or Dates:		••			
then tre M	Complete	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12th grade	ade completed) Coffege (1-4or 5+ 3 yrs.	(Give	dent's Usual Occupation kind of work done during most of w DO NOT use retired)		State of	Human Reso
E S S S	Ō	17. Father's Name (First, Middle, Last		D. 3-1:66			, Maiden Sumame)	
Health and Mental tem 27 is marked of ther traumatic even		Howard 19a. Informant's Name/Relationship	G.	Radcliffe	e Milo			oinson Zin Codel
Ith and 27 is m. r traum		Darlene Gilbert	Sister		17 E. Lanvale Str			
tem 2	1	20a. Method of Disposition			osition (Name of matory or other place)	Date	20c. Location - City of	
rtment ol rtant: If I njury or		1	fy)	King Mer		11-06	Randallst	own, Md.
Depa Impo any ir		Mondie	Wane		llOl E. North Ave	March F Balti	More, Md.	21202
iysician Medical		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Finaf disease or condition resulting in death)	one cause on each line a. Metasta	he death. Do not en atic Kidne consequence of):		ac or respiratory a	ırrest,	Approximate Interval Between Onset and Death 2 Years
physicien and Was the burial-transit and Andrea Examiner	CXamil	Sequentially fist conditions, if any, leading to instructions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):				
d by the attending petached for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Wood 9 Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (s <i>pecify</i>)		23d. Date of d Month	elivery Day Year
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page 2 shoul	Completed					24a. Was auto perfe 1 Yes		
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Sign P	2	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatien 28a. Date of Injury			Home 5 Rescribe	idence (Sp) ther (Sp) how injury occurred	Home
in in item	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not	on 28e. Pface of fniture	y - At home, farm, st	Work? M 1 Yes 2 No	28f. Location	Street and Number or	Rural Route Number,
al Dira	Ze l	4 Homicide	building, etc.	(Specify)		City or To	wn, State)	
	Medical	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	thysician: To the best of miner: On the basis of e and manner stat	examination and/or in	th occurred at the time, date and pla evestigation, in my opinion, death oc	ce, and due to the curred at the time,	cause(s) and manner date and place, and d	as stated, ue to the cause(s)
To ti comy	Σ	29b. Signature and title of certifier	Dam	MI	29c. License number 1W D3586	aylan	\$90. Date signed (Mo	onth, Day, Year)
		30. Name and address of person who NCA C. A. 31. Date filed (Month, Day, Year)	DAW50N 32. #egistral	MD.	Print) 22 S. Greene	St Bo	ettemore 1	ND 2120

The Entity Seem of the decision of pass some and number? The Supply Seem of the Seem of t			1 - For State Registrar	State of Maryland /		rtment of H tificate of L			_	006	2925
The July Short Service of Service Serv			Jessie			Rankin		Month	Day		3. Time of Death 2 1 2 2 2 M
246-54-9520 II		ner	The Johns Hopkins	Hospital	oirthday)	Baltimor	e City		N	A	Jaco (State or Fornic
Text le Mfg. College (1-4or 5+) Seamstress Text le Mfg.	Director		Usual Residence of Decedent	M 2X7F		Months Days	Hours Min.	(Month, Da	5–36	Coun	N.C.
Textle Mfg. College (1-4or 5+) Seamstress Textle Mfg.	the Marylan 28a-f ehow	ector	N.C. Rowan			eaf			10a Citizan		0d. Inside City Limits 1X Yes 2 □ No
Textle Mfg. College (1-4or 5+) Seamstress Textle Mfg.	after death with or Itema 23a or		1455 Hart Road 11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2√7 No	If	27054 Vas Decedent of Hi Yes, specify Cubar	n, Mexican, Puert	pecify Yes or No.	US.	A lace - Americ lack, White, o	an Indian,
Dear State (First Maddle, Maclan Summer) Lonnie Pruitt State (First Maddle, Maclan Summer) Hattie Protune 196 Mailing Address (Street and Number of Pruit Number, City or Town, State, 25 Code) Dearna Rankin Daughter 221 E. Hendertile St., Salisbury, N.C. 28144 220. Memor of Disposition Spland 2 Common 3 Chamber (Specify) Erwin Temple CME Ch. 21. Signature of Deposition Chart of State Spland 2 Common 3 Chamber (Specify) Erwin Temple CME Ch. 22. Nome and Address of Facility March F. H. East 1101 E. North Ave., Baltimore, Md. 21202 23. Part Erwin disease, crompiblishors has considered the death. Do not enter the mode of drying, such as cardiac of respiratory arrest. Information Countries and Spland 2 Countries (Specify) Provided and Spland 2 Countries (Specify) Provided Countries (Specify) Date of C	within 72 hours liene. r then "naturel", the Madical Exc	ompleted by	(Specify only highest grade	Year or Dates: ation 16: completed)	a. Decede (Give k life. D	ent's Usual Occupa ind of work done a O NOT use retired,	ition uring most of wor	king	16b. Kind of	Business/Ind	lustry
20a. Method of Disposition Committee of Date o		Be	17. Father's Name (First, Middle, Last)	Pruit	t				Maiden Sum		ne
23a. Part. Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Physician / Modical Examiner	of Hear		Deanna Rankin 20a. Method of Disposition 1 Deanna Rankin 2 Cremation 3 Recognition	Daughter 20b. Place cometo	221 of Dispos ery, crem.	E. Hende ition (Name of atory or other place	rtile St	., Salis	sbury, 20c. Location	N.C.	28144 wn, State
Physician (Medical Examiner) The part is a consequence of):	permit. Depertra Importe any nju		21. Signature of Funeral Service License	o Warrer			s of Facility	March F.	H. Eas more,	st Md. 2	21202
FFEMALE: 23b. Was decodent pregnant in the past 12 months?	/Medical Examiner	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or ringury that initiated events	Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence	epholo e of): er co	opathy	, such as cardiac	or respiratory an	rest,	2	Onset and Death
Section Part	the death certific by the ettending p		23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 2 ☐ Fetal death							•
Section Part	equires that en signed to ould be deta	þ	Part II. Other significant conditions conf	ributing to death but not resulting	in the unc	derlying cause give	n in Part I.				
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 39b. Signature and title of certifier 39b. Signature and title of certifier 39b. Signature and title of certifier 39c. License number 39c. License number 39d. Date signed (Month, Day, Year) 39d. Date signed (Month, Day, Year) 39d. Date signed (Month, Day, Year)	The ate h							autops	med?	death?	ipletion of cause of
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Justin Bachmann, Medical Doctor Res-000 September 8, 2006	spital or At ours after d nerat Direct filled in by		4 Homicide determined 29a. Certifier Market Certifying Physic	building, etc. (Specify) cien: To the best of my knowledge	e death	occurred at the time	a date and place	and due to the o	7, State)		
	To the Howithin 24 h	Medica	29b. Signature and title of certifier	and manner stated.	na/or inve	29c. License	nion, death occur number	red at the time, d	ate and place 9d. Date sign	ed (Month, D	the cause(s)
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	- C1/	to				rint) 00 North	Wolfe Str	et, Balt	imore /	Marylan	1 21287

Please Type or Print in E State of Marylan	Black Indelible Ink. Ensure And / Department of Health and	All Copies Are Legible. Mental Hygiene 2006	2925
	Certificate of Death	Reg. No.	
e (First, Middle, Last)	-1 1	2. Date of Death Month Day Year	3. Time of Death

		•	1 - For State Registrar	Olate of me	Ce	rtificate of			Reg. No.		LJLUI
			1. Decedent's Name (First, Midd	lle, Last)	_			2. Date of Dea Month		Year	3. Time of Death
	Physici /Medic			Margaret	Theresa	Rhodes			ber 9, 2		12:50 AM
	Examin		4a. Facility Name (If not institution	on, give street and number)		4b. City, Town, or	Location of Death		4c. County o		
			Angels Paradi				Burnie		Anne		
	Funeral Director		5. Social Security Number 212-52-0629	6. Sex 7. Age 7. Age 90	(In yrs. last birthday Yrs.) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day March	h V. Year) 20,1916	9. Birthplace Country Mary	
	pur *		Usual Residence of Decedent 10a. State 10b. County	,	10c. City, Town or L	ocation				10d	Inside City Limits
	e Maryla a-f eho	ctor		Arundel			Burnie				1 ☐ Yes ※XXNo
	h with th	ai Director	10e. Street and Number 7808 Baltimor	e & Annapolis	Blvd.	10f. Zip Code	21060		10g. Citizen of Wi United S		?
21215-0036	be filed within 72 hours after death with the Maryland tital Hygiene. bd other than "naturel", or tieme 23a or 28a-f ehow event, the Madical Examiner must be notified at	l by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Mai 3 ☑ Widowed 4 ☐ Divorce	If Yes Give	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No		ecify Yes or No- Rican, etc.)	14. Race Black Specify:	- American , White, etc. Wh	
5-0	72 h	Completed	15. Decede (Specify only highe	nt's Education est grade completed)	16a. Dece (Give	edent's Usual Occup e kind of work done o DO NOT use retired	ation during most of work	ing	16b. Kind of Bus	iness/Indus	stry
121	within ene. than	E E	Elementary/Secondary (0-12)	College (1-4or 5	+)		1)		Or	un Hon	mo.
2	al Hygie other t		10 Years 17. Father's Name (First, Middle	(act)		Homemaker	18. Mother's Name	a /First Middle		wn Hon	lle
Maryland	ould be f Mental I Mrked of	Be	Lawrence He					lian Web		,	
Z	2 should and Men le marke aumatic	ဥ	19a. Informant's Name/Relation		19b. Mail	ing Address (Street	and Number or Rura	al Route Numbe	ar. City or Town. S	itate. Zip Co	ode)
Za	d 2 th a tra		Lawrence W. R			2 King Ri			usville,		32796
Baltimore,	of Heel of Heel If item?		20a. Method of Disposition 12 Burial 2 ☐ Cremation	3 □Removal from State	20b. Place of Disp cemetery, cre	osition (Name of ematory or other place	(9:	Date	20c. Location - C	City or Town	, State
Ë	Pag tment tent:		4 □Donation 5 □ Other (Specify)		n Cemeter		3/2006	Baltim	ore, l	Maryland
Bal	permit. Pages 'Department of Himportant: If its eny injury or of once.		21. Signature of Funeral Service	Licerispee . (a		2. Name and Addre Duda-Ruck 1922 Wise	Funeral	Home of	Dundalk Maryland	, Inc 2122	22
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that caused tonly one cause on each lin	the death. Do not en					Ar	pproximate terval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	- Olu	rental a consequence of):					1	nset and Death
		iner	Sequentially list conditions, the same to manage cause. Enter Underlying Cause (Disease or injury	b	a consumence of):						
	and I-trans	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					_	
68760,	icate be executed physician and the burial-transit			d							
	ntifica ng ph as th	Medicai	IF FEMALE:								
.O. Box	The law requires that the death certificate be executed site has been signed by the ettending physician and bage 2 should be detached for use as the burial-transit	Physician/N	23b. Was decedent pregnant in the past 12 months 1 Yes 2 Who 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date Mont	of delivery th Da	ay Year
<u>α</u>	res that igned b be deta	þ	Part II. Other significant condit	ions contributing to death bu	ut not resulting in the	underlying cause giv	en in Part I.		obacco use contrib		
orc	v requir been si should	eted						1 D Y	res 2.⊒Hro 3	Probabi	ly 4 Unknown
Vital Records,	The law sete hes b page 2 st	Completed							pr rmed? pr	ior to compleath?	findings available letion of cause of
ita	certifice rector, p	Be	25. Was case referred to medical examiner?	al			26. Place of Deat				11112
of V	Physician: this certific ral director,	흔	1 ☐ Yes 2 🗓 No		nt 2 ☐ ER/Outpatie		4 Nursing Ho		lence 6 Dother		Assisted
ion	ding h. After fune	ation;	27. Manner of Death 1. Hatural 5 Pendi 2 Accident investi	ing 28a. Date of Injur (Month, Day	y Year) 28b. Time Injury	Wor	yat k? Yes 2 □No	28d. Describe h	ow injury occurre	d	Crong
Division	al or Atten s after deat I Director; d in by the	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deten	not be mined 28e. Place of Injubuilding, etc	ury - At home, farm, s c. (Specify)	treet, factory, office		28f. Location (S City or Tow	Street and Number vn, State)	r or Rural R	oute Number,
	To the Hospital or within 24 hours after To the Funerel Direction completely filled in b	Medical C	29a Certifier 1 ertify (Check only 2 Medica	ing Physician: To the best I Examiner: On the basis of and manner sta	examination and/or is	th unnumed at the tin nvestigation, in my o	ne date and place. pinion, death occur	and due to the red at the time, o	tause(s) and man date and place, ar	ner as state nd due to the	e cause(s)
)	To the within 2 To the complet	Me	29b. Signature and title of certific		l. l	29c. Licens	e number	16	29d. Date signed	(Mofith, Day	y, Year)
,	h		30. Name and address of person	who completed cause of d	eath (Tem 23) (Type	Prior	2009	7 Bun	1	1 7	1061
)×	Sta		31. Date filed (Month, Day, Year	Ha.	ar's Signature	INC II	14 00	1/01	nry M	41,0	1041
	Registr	ar	SEP 1 4 20	06	12. William						

Registrar DHMH 17 Rev 1/2001 SEP 1 4 2006

		•	1 - State Registrar	State of Ma	ryland		rtment of I rificate of			giene Reg. No. 2	006	29252
	Physici	an	1. Decedent's Name (First, Middle, La	st)	,	,	-		2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Medic	al .	4a. Facility Name (If not institution, giv	e street and number)	αρρ.	aport	4b. City. Town.	or Location of Deatl	Septem		2006 nty of Death	23:46
	Examin	er	Mercy Medical Center				Baltimore			N/A		
	Funeral Director		5. Social Security Number 6. S 218-30-5554	ex 7. Age	(In yrs. 12 72	ast birthday) _ Yrs.	if Under 1 Year Months Days		8. Date of Birt (Month, Date 04/20/	1934	9. Births Coul	placa (State or Foreign ntry) NY
	land ow	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location								1	10d. Inside City Limits
	2 should be filed within 72 hours after death with the Maryland and Menial Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Madical Examiner must be notified at		MD HOWARD			ELLICOTT CITY						1 Tes 2 No
			10e. Street and Number 12035 WINDSOR MOSS			10f. Zip Code 21042				10g. Citizen i		ntry?
21215-0036			11 Marital Status 12. Was Decede		nt Ever in U.S. 13.		Vas Decedent of Hispanic Origin? (Spet f Yes, specify Cuban, Mexican, Puerto F		pecify Yes or No-		14. Race - American Indian,	
			1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☑ Yes 2 ☐ No If X es, Give Year or Dates:)		′es, specify Cuban, Mexican, Puerto Rican, etc.) □ Yes 2 ⊠ No <i>Specify:</i>			Black, White, etc. Specify: WHITE		
5-0	"natu		15. Decedent's E (Specify only highest gra	ucation 16a. de completed)		16a. Decede	a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TORNEY			16b. Kind of Business/Industry LAW		
212	d 2 should be filed h and Mentat Hygi 7 is marked other traumatic event, it		Elementary/Secondary (0-12)	College (1-4or 5+) AT		ATTORN						
			17. Father's Name (First, Middle, Last	DΛ					(First, Middle, Maiden Sumame)			
Maryland			MAX A RAPPAPORT LILLIAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run							r City or To	un State Zir	GALKA
			MARGY RAPPAPORT	/ WIFE					ELLICOTT			
more,	permit. Pages 1 and Department of Heals Important: If Item 2 any injury or other ance.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	Ce		atory or other pla	1	Date		n - City or To	
Ē	it. Pag riment riant: njury c		4 Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lice)	(y)	¢res	TLAWN N	MEMORIAL	PARK 09	/13/2006	MARRI	OTTSV1	ILLE, MD
Balti	Depa Impo any is		21. Signature of Fuller Service Lice	and un				ess of Facility S(
	eath certificate be executed x attending physician and for use as the burial-transit		23a. Panti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate									Interval Between
			Immediate Cause (Final disease or condition a. Aspiration Presumaitis Onset and Death								Onset and Death	
ı			1	Due to (or as a consequence of): Due to (or as a consequence of):								
		ed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to infinite diate cause. Enter Underlying									
38760, A			Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of):								
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Вох	ath ce attendi for use		23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (specific)							23d. Date of delivery Month Day Year	
Р. О.	the de		1 Yes 2 No 9 Unknown	4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown								
	The law requires that the death certif te has been signed by the attending age 2 should be detached for use a		Part II. Durier significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
eco	ie law requir has been si ge 2 should t	Completed							24a. Was	sy	prior to co	psy findings available mpletion of cause of
<u>~</u>	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	edical Certification; To Be Con									210 No	
Division of Vital Records,			axaminer?								(v)	
			27. Manner of Death 1 Maturat 5 Pending 2 Accident investigatio	28a. Date of Injury 28b. Time of South, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred								
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			29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	To the within To the comp	Me	29b. Signature and title of confiner				1	se number	I .	29d. Date sig		*
,	1		· MA	1	Ditton			P19694	+	_ Se	ptember	- 10, 200E
	3,1		30. Name and address of person who	3 - 1	ath (Item		Place	Batton	nore M	0	21201	- 10, 2006
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 Certificate of Death 2 Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Robert Sautter 09/13/2006 6:45 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1950 Brady Ave. Baltimore Halethorpe If Under 1 Year Ti Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/16/1959 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 □ F 213-80-8045 Director 47 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits ehow. er then "naturel", or Itame 23a or 28a-f ehov The Medical Examiner must be notified at 1√2 Yes 2 No MD Baltimore Halethorpe Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1950 Brady Ave. 21227 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No ff Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 2□No Specify: Specify: þ White 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Crew Chief 12 Local Government permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event gines. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robert G. Sautter Helen Schumaker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherri Sautter / Wife 1950 Brady Ave., Halethorpe, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cedar Hill 09/16/2006 Brooklyn Park, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, INC. 17250 washington Blvd., Elkridge, MD 21075 MO1234 23a. Part1. Enter the disease, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MonThs ESOPHAGEAL CANCES Immediate Cause (Final METASTATIC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine Hospital or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. lan/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Physicia 4☐ Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been (24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performe 2/2/No 1 ☐ Yes funeral director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Injury at 28d. Describe how injury occurred Hospitaf: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes 2 XNo ٩ this 27. Manner of Dath 1 Natural Accident 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: After 5 Pending 1 Yes 2 No death. investigation the tor 3 🗌 Suicide 6 Could not be determined 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of confier D16354 CI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON ANG BALTIMORE MO 21229

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, SEP

ST AGNES

gistrar's Signature

			1 - State of Maryland / Dep Registrar Ce	artment of Health and Mertificate of Death	lental Hygier	e2006	29254
n 2 9		e.	Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year	3. Time of Death
	Physicia /Medic		THOMAS ALOYISUS SWEENEY, JR.		3	3 2006	2:43AM
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		tc. County of Death	
		### #	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	of Under 1 Year If Under 24 Hrs.	8. Date of Birth	N/A 9. Birthol	lace (State or Foreign
	Funeral Director		217-22-4784 17 × 2□F 82 Yrs.	Months Days Hours Min.	(Month, Day, Yea	24 Mary	try)
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the	7288-	Director	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Coun	try?
h with	23a ol		924 Regester Avenue	21239		USA	
r deal	ems er mi	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - America Black, White, e	
III C I C I C I S-0050 be filed within 72 hours after death with the Maryland	i, or i	by Fu	1 □ Never Married 2 【X Married 1 【X Yes 2 □ No IF Yes, Give Year or Dates: WWTT	1 ☐ Yes 2 No Specify:		Specify: Thi	te
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Lithin 7	en "n	Completed		DO NOT use retired)	St	ate of Mai	
w pell	her th		17. Father's Name (First, Middle, Last)	Dervisor	(First, Middle, Maid	pt of Heal	rtu
d be f	c evel	o Be	Thomas Aloyisus Sweeney, Sr.		Cecilia		
should	and Mentar hygiens is marked other then "naturel", or liems 23a or 28s-f show aumatic event, the Medical Examiner must be notified at	ြ		ing Address (Street and Number or Rura			Code)
≥ ヮ:	= -=		Mary Egan Sweeney (Wife) 924 F	Regester Avenue, Ba	ltimore.	Maryland_2	21239
988 1	or of		1 ▼ Burial 2 □ Cremation 3 □ Removal from State cemetery, cre	ematory or other place)		200 100-10	
altimo	Department of Healinportant: If Item 2 ony injury or other once.	1	(I)	edral Cemetery 9/1			Maryland
permit.	Impo eny ir		Jawson 1	2. Name and Address of Facility Mitchell—Wiedefeld 5500 York Road, Bal			1212
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cuted	nd ransit	Examiner	ff any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
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Don Bridging	th. : After e fune	tlon	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation 28a. Date of Injury (Month, Day Year) Injury	of 28c. Injury at Work? M 1 □ Yes 2 □ No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
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To the	within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Me	29b. Signature and title of certifier	29c. License number	1	Date signed (Month, I	
	-		► Harwar MBOUGERGI, M.D.	RESOOO		9,14,20	06
	10		30. Name and address of person who completed cause of death (Item 23a) (Type		GC PTTA/	, BALTIT	IDDC
100	Sta	ate	MARWAN ABOU 6 GG I M. D. GOOL 31. Date filed (Month, Day, Year) 32. Register's Signature	SAMARITAN 1	UNITIO	1 UNC 1.11	TUNE
	Registr		SEP 1 4 2006	Goesti)			

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State of Maryland / Department of Health and Mental Hygiene 2006

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			1 - State Registrar	State of Marylan		cate of Death	Reg		27200					
Ph	hysicia	an	Decedent's Name (First, Middle, Last)	C 1	\		2. Date of Death Month	Day Year	3. Time of Death					
. /	Medic xamin	ai	4a. Facility Name (If not institution, give s	treet and number)	wart	City, Town, or Location of Deat	l'eptembe	4c. County of Death	0702 AM					
, -	Adillill	ei	Since Hospital	of Bulhin		Baltimore lity		, , , , , , , ,						
	neral ector		5. Social Security Number 6. Sex 1 Usual Residence of Decedent	7. Age (In yrs.)	Ma	Under 1 Year If Under 24 Hrs enths Days Hours Min.		9. Birthp Cour	place (State or Foreign htry)					
yland	=		10a. State 10b. County	10c. City	y, Town or Locatio	n		1	Od. Inside City Limits					
e Mar	Mille	ctor	MD		٢	Baltimor	ع		1 Yes 2 No					
death with the Maryland	Den	Funeral Director	10e. Street and Number	. 0 4 0	10	Of. Zip Code	10g	. Citizen of What Cour	ntry?					
death		nerai	1763 Whit-	E. U.A. H 12. Was Decedent Ever in U.	S. 13. Was	2134 Decedent of Hispanic Origin? (S s, specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - Americ	can Indian,					
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene.	Examine	by	1 Never Married 2 Married 3 Widowed 4 Dervorced	Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates:		s, specify Cuban, Mexican, Puer (es 2 12 No Specify:	to Rican, etc.)	Black, White,	hite					
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Page	ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	etwo Cre	· · · · · ·	15-06	Balto, 1	ND					
Baltimore, permit. Pages 1 a Department of Heal	any inj		21. Signature Funer Service License			me and Addr s of Facility M 1232 Mic Vo		sup, PA	14.20 14.20					
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of Vita Physician:	al dire	<u>و</u> _	1 ☐ Yes 2 ☐ No					e 6 □Other (Specify	1)					
On olding f	funer	tion:	27. Manner of Death 1 ☑ Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 1 Yes 2 No	28d. Describe how i	njury occurred						
Division I or Attending after death. Director: After	in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, fa		28f. Location (Stree City or Town, S	t and Number or Rura tate)	l Route Number,					
Division of Vital Rec To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has	letely filler	Medical C	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death occi ion and/or investig	urred at the time, date and place gation, in my opinion, death occu	, and due to the caus cred at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)					
To the Within	сошр	Me	29b. Signature and title of certifier			29c. License number		Date signed (Month, i						
			> zedenly Signl	•		P60693		ptember i	7, 2006					
	3		30. Name and address of person who con ANDEN (5. PEDP 31. Date filed (Month, Day, Year) SEP 1 4 2	mpleted cause of death (Item	23a) (Type Print)	it of Rushing	orl							
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1	Exa	aminer
Division of Vital Records, P.O. Box 68760,	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death	To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

		For State Registrer	State of Marylar		artment of h			giene Reg. No. 2001	6 29256		
Physicia /Medic		DANIEL PAU	UL SADO	WSKI	· · · · · · · · · · · · · · · · · · ·		2. Date of De	ath	3. Time of Death 11:34a M		
Examin		4a. Facility Name (If not institution, give st STELLA MARIS			TOWSO			4c. County of Death BALTIMORE			
Funeral Director		5. Social Security Number 219225774 Usual Residence of Decedent	7. Age (In yrs. 7	last birthday) 9 Yrs.	If Under 1 Year Months Days		(Month, Da	th Year) 9. B 7, 1927 MA	irthplace (State or Foreign Country) RYLAND		
be filed within 72 hours after death with the Maryland tal Hyglene. d other then "naturel", or items 23s or 28s-f show event, if a Modical Examiner must be notified at	tor	10a. State 10b. County MD BALTIMOR		ty, Town or Lo					10d. finside City Limits 1 ☐ Yes 2 No		
with the	Funeral Director	10e. Street and Number			10f. Zip Code	_		10g. Citizen of What C	*		
leath y	erai	1315 CHESACO AV	E APT#327 2. Was Decedent Ever in U		2123 Was Decedent of I		Specify Yes or No	US			
permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylar Depertment of Health and Mental Hygiene. Important: it item 27 is marked other then "naturel", or items 23s or 28s-f show any injury or other treumatic event, the Modical Examiner must be notified at once.	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 14∑Yes 2 No		f Yes, specify Cub 1 ☐ Yes 2 🗷 No	Hispanic Origin? (Sean, Mexican, Puer Specify:	to Rican, etc.)		nite, etc. WHITE		
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0		30. Name and address of person who con DR. TARIO MAHMOO			*	ТТМО МТТ	w wn 91	003			
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	State of Maryland / Department of Health and Mental Hygiene 2006	2923

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Examir Funeral	ier	4a Facility Name (If not institution, give s Per Company Number 6. Sex	7. Age (In yrs. Ias	er B	ulTIM	8. Date of Birth (Month, Day,	Year) 9. Birthplace (State or Forei
Director		219-70-5102 Usual Residence of Decedent 10a. State 10b. County	51 10c. City,	Town or Location		06/26/1	955 Maryland 10d. Inside City Limi 1 Yes 2
natural', or itema 23a or 28a-f ehow Jigal Examinar must be notified at	Director	Maryland Baltimor 10e. Street and Number	e Qwyn	Oak 10f. Zip	Code	1	0g. Citizen of What Country?
nal Hygiene. er other than "natural", or itema 23a or 28a-f ehow event, the Medical Examiner must be notified at	Completed by Funeral I	5912 Cecil Avenue 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes	ent of Hispanic Origin? (S ify Cuban, Mexican, Puerl No Specify:	pecify Yes or No- to Rican, etc.)	United States 14. Race - American Indian, Black, White, etc. Specify: White
ene. than "natu ta Medical	mpletec	15. Decedent's Educification (Specify only highest grade	completed) College (1-4or 5+)		k done during most of wo e retired)	rking	16b. Kind of Business/Industry
Mental Hygiene. arked other than " atic event, the Me	Be	17. Father's Name (First, Middle, Last) Cesar Surdokas	4	Collection		me (First, Middle, M	Office Equipment Maiden Sumame)
th and 7 is m traum	2	19a. Informant's Name/Relationship (Ty) Christel Surdokas	1				; City or Town, State, Zip Code)
Department of Heal Important: If Item 2 any injury or other once.		20a. Method of Disposition 1 ♣Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State 20b. Pla cer Loud	ce of Disposition (Nametery, crematory or o	me of ther place) metery 09/1	Date 6/2006	20c. Location - City or Town, State Baltimore, Maryland
Depart Import any n		21. Signature of Funeral Service Census	Veles)	5311 E		enue Balt	imore, Maryland 212:
was been signed by the attending physician and care been signed by the attending physician and page 2 should be detached for use as the burial-transit	sal Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that nitiated events resulting in death) Last	Interval Between Onset and Death MONTA				
by the attending phys	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnant 1 Live birth 2 Fetal c 4 Pregnant at time of dea	death 3 Ectopic pr			23d. Date of delivery Month Day Year
n signed by Ild be deta	þ	Part II. Other significant conditions cor	ntributing to death but not result	ting in the underlying o	ause given in Part I.		bacco use contribute to the cause of death?
cate has been si , page 2 should	Completed					24a. Was a autops perforr 1 □ Yes	y prior to completion of cause
ih. : After this certifica funeral director, p	tion: To Be	27. Manner of Death 1 Natural 5 Pending		R/Outpatient 3 DC 28b. Time of Injury	Other		ence 6 Other (Specify) ow injury occurred
dea ctor y the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28f. Location (St City or Town	treet and Number or Rural Route Number, n, State)			
within 24 hours after To the Funeral Dire completely filled in b	Medical C	(Check only 2 Medical Exami	sicien: To the best of my knowner: On the basis of examination and manner stated.	on and/or investigation	in my opinion, death occi	urred at the time, d	ate and place, and due to the cause(s)
E 0 E	2	29b. Signature and title of certifier 30. Name for address of person who co		-	License number		9d. Date signed (Month, Day, Year)
To con				20-1/7	100 13	6	greater to po

Physicia /Medic Examin

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "naturel", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examination in confiled at once.

Physician

Veronica Satterfield Mizloc 1130 pm

/Medical Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

For State Registrar	State of Maryland	Depa / Depa	rtment of H	ealth a Death	and Mental	Hygien		06	29258
1. Decedent's Name (First, Middle, Last) Veronica K.	Satterfield				Mont	of Death th D ember	12, 2	Year 2006	3. Time of Death 11:20 p ^M
4a. Facility Name (If not institution, give st Oak Crest	reet and number)		4b. City, Town, or Baltimon				c. County o	f Death	
	7. Age (In yrs. last 93	birthday) Yrs.	If Under 1 Year Months Days	If Under: Hours		of Birth th, Day, Yea	(⁹ 12		ace (State or Foreigi 1797) and
Usual Residence of Decedent 10a. State 10b. County Md. Baltimor	e Balt	own or Loc imore					10	0d. Inside City Limits	
10e. Street and Number 8828 Walther Blvd	. #4001		10f. Zip Code 2123	34		10g. C	itizen of Wi		rry? ISA
11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Pes 2 XNo If Yes, Give Year or Dates:	lf lf	/as Decedent of His Yes, specify Cubar ☐ Yes 2 No	panic Orig , Mexican Specify:	or No- c.)	14. Race Black Specify:	, White, e	otc.	
15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed)	(Give k	ent's Usual Occupa kind of work done d O NOT use retired) tary	Kind of Bus		ustry			
17. Father's Name (First, Middle, Last) Unknown	1	Knea	vel	18. Mothe	r's Name <i>(First, N</i> Na	Maide, Maide	n Sumame	Ruc	k
19a. Informant's Name/Relationship (Type Ms. Ruth Fairbank/	Daughter	906	Address (Street a		apolis,	Md. 21	.401		
20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 ☒ Other (Specify E) 21. Signature of Funeral Servica Licensee	ntombment Dula	_{etery, crem} ney V	Name and Address	. 9	-15-06 yn Funera Rd. Tows	Ti	moniu 212	ım, M	
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, I any, become to the following to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consequent	ce of):	hyparl		Uisease				
IF FEMALE: 23 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₩ 0 9 □ Unknown	ic. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 4 Pregnant at time of death 9 Unknown	ath 3 🗆	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year				
Part II. Other significant conditions cont	ributing to death but not resulting	_	derlying cause give	n in Part I.	23e.				e cause of death?
					24a.	Was an autopsy performed? Yes 2 N	pri de	ior to com	esy findings availab apletion of cause of 2 No
25. Was case referred to medical examiner?	ospital:		3/7 DOA Othe		of Death (Check			10	
27. Manner of Death 1	1 □ Inpatient 2 □ ER	Outpatient b. Time of Injury	28c. Injury Work	4 190		Residence)
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	et, factory, office			tion (Street a or Town, Sta		r or Rural	Route Number,
(Check only 2 Medical Examine one)	cian: To the best of my knowled er: On the basis of examination and manner stated.	dge, death and/or invi	estigation, in my op	nion, deal	d place, and due t th occurred at the	time, date ar	nd place, ar	nd due to	the cause(s)
29b. Signature and title of certifier	nco		29c. License		2		te mb		Day, Year)
30. Name and address of person who con Amag Menias 31. Date filed (Month, Day, Year) SEP 1 4 2006		. I tha	e Bow	4000	rd Par	rkuill.	, v	(1)	21234

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Sta Registr Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2006

			1 - For State Registrar	State of M	1 arylar	id / Depa <i>Cei</i>	artme <i>rtifica</i>	nt of H	lealth ar Death	nd Me		iene 2	006	29259
	Physici /Medi		Decedent's Name (First, Middle, John	·	ward		S	Savao	qe Jr		Date of Death Month	Day	Year 2006	3. Time of Death / :30 A M
,	Examir		4a. Facility Name (If not institution,	give street and numbe	r)		4b. City	, Town, or	Location of		,	1	nty of Death	
			Union Memori	al Hospit	al		Ва	altin	nore				NA	
	Funeral Director		577-38-5788	6. Sex 7. A	nge (In yrs. 89	last birthday) Yrs.	If Und Months	Days	If Under 24 Hours	Min.	Date of Birth (Month, Day, 2 19	Year)	9. Birthpla Country	ce (State or Foreign v) VA
	and **		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						100	1. Inside City Limits
	Aaryte	ō	MD N	Δ		altim							1.55	1 √ Yes 2 No
	28a-	ect	10e. Street and Number			arcrii.		ip Code			10	On Citizen o	f What Country	
	with with	ā	4236 Evans Ch	anel Road			1011.2		1211			_	J.S.A.	, .
	Jeath Te 2:	era	11. Marital Status	12. Was Deceden	t Ever in U	.S. 13. \	Nas Dec			n? (Specif	y Yes or No- can, etc.)		ace - Americar	n Indian,
21215-0036	d within 72 hours after death with the Maryland Jone. Ir than "natural", or Items 23a or 28a-f ahow Ithe Madical Examinar must be notified at	by Funeral Director	1 ☐ Never Married	Armed Forces od 1 X Yes 2 [If Yes, Give Year or Dates] No		_	ecify Cuba	n, Mexican, I Specify:	Puerto Rio	can, etc.)	Spec	lack, White, etc.	c. ack
Š	72 hou	ted	15. Decedent	s Education		16a. Deced	dent's Us	ual Occupa	ation			6b. Kind of	Business/Indu	stry
215	within 7. ene. then "n	pie	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4o	r 5+)	life.	kind of w DO NOT	rork done d use retired	during most o ()	of working				
7	od wit	Completed	12th grade	na		Let	ter	Cari	cier		U	.S. P	ostal	Service
ם	be filed ital Hygie of other	Be (17. Father's Name (First, Middle, L	ast)					18. Mother's	s Name (F	First, Middle, M	faiden Suma	ame)	
<u>ya</u>	Ment Ment arkec	1 -	John E. Savag	e Sr.					Mary	Lee	Bogg	5		
Maryland	2 shoul and Ma Is mari		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	g Addres	ss (Street a	and Number	or Rural F	Route Number,	City or Town	n, State, Zip C	ode)
	s 1 end 2 should if Heelth and Men Item 27 Is marke other traumatic		Victoria Sava	ge-Daught	er	9445	Clo	ckto	wer 1	Lane	. Col	umbia	, Md	21046
ore	of Hee		20a. Method of Disposition **D Burial 2	3 □Removal from Stat		Place of Dispo cemetery, crem				Date			n - City or Town	
Baltimore,	permit. Pages 'Depertment of H Important: If Ite any injury or of		4 □ Donation 5 □ Other (Sp	ecify)	Ga	rriso	n Fo	rest	: Vet	. 9/	15/06	Owin	ıgs Mi	lls, Md
3all	Depending Depending May in page.		21. Signature p Funeral Service L	icensee	115				s of Facility I Wesi	+-				
	<u>v</u> ∪ = • α		/ / www.	O. Yough	G_	4	300	Waba	ash A	ve,	Balti	nore,	Md,	21215
	Physician	,	23a. Part1. Enter the disease, or o shock, or heart failure. List o fmmediate Cause (Finaf disease or condition	nly one cause on each	fine.	h. Do not ent					espiratory arre	st,	lr lr	opproximate nterval Between Onset and Death
1	/Medical		resulting in death)	Due to (or a	s a conseq	uence of):	2119		VII C C	٦				170
	Examiner		Sequentially list conditions,	b										
	ס #	Examiner	r any, leading to immediate cause. Enter Underlying	Due to (o. a	s a conseq	uence of).								
	ate be executed hysicien end he burial-transit	am	Cause (Disease or injury that initiated events resulting in death) Last	c										
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87	hysic the b	dicai		d										
x 68	es that the death certifica igned by the ettending ph be deteched for use as th	by Physician/Med	IF FEMALE:	222 #										
Box	ath c	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	2 Feta	fdeath 3		pregnancy					ate of delivery fonth D	ay Year
0.	the e	/stc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown	at time of d	eath 5∟	Other (specify)						-,
<u>α</u>	The law requires that the site has been signed by the bage 2 should be deteched.	P.	Part fl. Other significant condition	s contributing to death	but not res	ulting in the ur	derlying	Called Olive	an in Part I		23e Did toh	acco use co	ntribute to the	cause of death?
ds,	signe d be				5411141155	g a.	donying	oudso give	or with art i.			s 2 □ No		ely 4 □Unknown
Ö	w requir been si should	Completed												
š	e law hes	qu									24a. Was an autopsy		. Were autops prior to comp death?	y findings available eletion of cause of
al											perform 1 ☐ Yes 2	/19		No
Ĭ.	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				Othe	35		Check only one			
of Vital Records,	Phys this ral di	5. T	1 ☐ Yes 2√2 No 27. Manner of Death	28a. Date of In		ER/Outpatien 28b. Time of		28c. Injury	4 Idurs		5 Resider			
	ding Phy h. After thi funeral o	tion	1√ZNatural 5 ☐ Pending	(Month, D	ay Year)	Injury	м	Work	rat (? Yes 2 ∐ No		z. Describe no	w inquiry occu	21160	
Division	Attending r death. ector: After by the fune	Certification;	3 ☐ Suicide 6 ☐ Could n	ot be 200 Bloom of the	naurv - At h	ome farm str			103 2 110		Location (Str	eet and Num	nber or Rural F	Poute Number
S	after Dire	erti	4 ☐ Homicide determin	building,	etc. (Specif	y)	cot, racto	ry, onice			City or Town,		noor or riangri	iodio ivamber,
	To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai C	(Check only 2 Madical E	Physician: To the bes	of examina	wledge, death	occurre	d at the tim	ne, date and pointion, death	place, and occurred	due to the ca at the time, da	use(s) and n	manner as state	ed. ne cause(s)
	thin 2 the the mple	Med	one) 29b. Signature and title of certifier	and manner s	stated.			c. License					ned (Month, Da	
	7. ₹ 5. 8									2		_		
,	180		CHECO 15	wacine		MO		DO	5631	+6		xplen	16e+ 12	12006
	00		30. Name and address of person v	> i				4 1 10	, , (lnio	M	4.00	1	-12006 Ospital.
	Sta	at a	31. Date filed (Month, Day, Year)	32. Red	trar's Signa	neme	2	MY	,	~1110	U lel	KANO	191 H	uspited,
	Registi		SEP 1	4 2006	Election .	K 1	Sonal Const	000						

State of Maryland / Department of Health and Mental Hygiene, 29260 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 10, MAUDE L. TUCKER SEPT 2006 7:30 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner COLUMBIA HOWARD 5337 COLUMBIA RD. #D If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1□M 2□F Yrs. Director MARCH 30, 1928 287.24.9417 78 NC Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits if item 27 is marked other than "netural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director MD HOWARD **COLUMBIA** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene Important; if item 27 is marked other than "netural", or items 23a any jointy or other traumatic event, the Medical Examiner means once. 5337 COLUMBIA RD. #D 21044 Funeral USA 12. Was Decedent Ever in U.S. Armed Forges?

1 Yes, 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: þ 3 Widowed 4 □ Divorced Specify. BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) HEALTH CARE 12 NURSES ASSISTANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) PATTIE PEANSE WILLIE H. DEMORY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAUGHTER 5337 COLUMBIA RD. #D COLUMBIA, MD 21104 DEBBIE BRITTON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XXBurial 2 Cremation 3 XXPemoval from State ' 4 ☐ Donation 5 ☐ Other (Specify) CREENLAWN CEMETERY SEPT. 15,2006 AKRON, OH 21. Sign 22. Name and Address of Facility
FINK FUNERAL HOME, P.A. CRECORY KINK 1101148 426 CRAIN HWY SW GLEN BURNIE, MD 21061 ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ause on each line. nter the disea Approximate Interval Between Onset and Death or heart failure Immediate Cause (Final disease or contion resulting in death) Physician EAR lterine ancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transil Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? (es 2 No 1 Yes the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Matural 28b. Time of Injury Certification: 28d. Describe how injury occurred Injury at Work? To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Grantifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed Month, Day, Year) PHYSICIAN D53590 06 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 24 N BROADWAY BALTIMORE 21205 MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

		-	For State Registrar	of Marylan		tment of H			giene Reg. No. 20	06 2	926
	Physicia /Medic	ın	1. Decedent's Name (First, Middle, Last) Geneview A	Taylor	-			2. Date of De Month	Day	Vone	ime of Death
	Examine	er	sa. Facility Name (Il not institution, give street and Baltimure Washington M	odical Cor	nto-	Glan B		h	4c. County	Arund	له
	Funeral Director		5. Social Security Number 6. Sex 215-12-7345 1□ M 2型 Usual Residence of Decedent	7. Age (In yrs. 84	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da 03/03	th y, Year) 1/1922	9. Birthplace (Country)	State or Foreign MD
	death with the Maryland ms 23s or 28s-f show rittest for multified at		10a. State 10b. County MD Anne Arunde1		y, Town or Loca Glen Bur						ide City Limits ⊇Yes 2⊠No
H.	h with the	al Director	10e. Street and Number 7417 B & A Blvd.			10f. Zip Code 21061			10g. Citizen of W	,	
36	urs after deat	by Fur	1 Never Married 2 Married 1 ☐ Yes	Decedent Ever in U. d Forces? es 2 XNo , Give or Dates:	lf	as Decedent of H Yes, specify Cuba	ispanic Origin? (S in, Mexican, Puer Specify:	pecify Yes or No to Rican, etc.)		e - American Ind k, White, etc. white	,
1/0R (SEX)E 1/1E 1/5 timore, 1Maryland 21215-5036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene Important: If Item 27 is marked other than "natural", or Itams 23e or 28e-f show Important: If Item 27 is marked other than "natural", or Itams 23e or 28e-f show any injury or other treatmatic event, the Medical Examinat mail be invitibled at once.	Completed	15. Decedent's Education (Specify only highest grade complet Elementary/Secondary (0-12) Colleg	red) ge (1-4or 5+)	(Give k	nt's Usual Occup ind of work done of NOT use refired naker	ation during most of wo	rking	16b. Kind of Bu		
A)E	uld be filed Mental Hygirked other tic event, I	To Be Co	17. Father's Name (First, Middle, Last) George A. Headley					me <i>(First, Middl</i> e, ne MacLe	Maiden Sumam 11an	е)	
Mary (and 2 shouealth and N n 27 is ma		19a Informant's Name/Relationship (Type, Print) Mr. Arthur W. Taylor,	Sr.	7417	B & A B		n Burnie	er, City or Town,	061	
1/0R timore	. Pages 1 tment of H tant: If Iter		20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal fi 4 ☐ Donation 5 ☐ Other (Specify)	rom State	adowrid	atory or other place ge Memor	ial 09/		Elkrid	ge, MD	
Bal	Deper Deper Impor		21. Signature of Funeral Service Licensee	- Me					Funeral urnie, l		
8760,7	Physician /Medical Examiner physicien and the priral-(ransit the priral-(ransit physician) physician and physician and physician and physician and physician and physician and physician p	dical Examiner	resulting in death) Esquentially liet compitions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	on say and cell of to (or as a consequence of to (or a))).	uence of):	cinoma	, meta it	atic		Onse	al Between
P.O. Box 6	ath certifii ttending p	Physician/Me	in the past 12 months?	, outcome of pregna ive birth 2 □ Feta regnant at time of d Inknown	il death 3 □	Ectopic pregnancy Other (specify)		- 201	23d. Dat Mor	e of delivery onth Day	Year
rds, P.	v requires that the de been signed by the a should be detached f		Part II. Other significant conditions contributing	to death but not res	ulting in the und	derlying cause giv	en in Part I.	23e. Did t	obacco use contr Yes 2 PNo	ibute to the cau	
al Reco	The law ete has b page 2 sl	Completed by						24a. Was auto perfo 1 □ Yes	psy prmed2	Vere autopsy fin irlor to comptetio leath?	
Division of Vital Records,	To the Hospitel or Attending Physician: Th within 24 hours efter death. To the Funaral Director: After this certificete completely filled in by the funeral director, pag	atlon: To Be	the state of the s	1 Inpatient 2 Date of Injury Month, Day Year)	ER/Outpatient 28b. Time of Injury	3 DOA Oth	er: 4 ☐ Nursing I		one) dence 6 □Othe how injury occurr		
Divis	tel or Atters effer des	Certification:	3 Suicide 6 Could not be determined 28e.	Place of Injury - At houlding, etc. (Specif	ome, farm, stre	et, factory, office		28f. Location (City or To	Street and Number wn, State)	er or Rural Rout	e Number,
	he Hospi n 24 hour he Funar pletely fill	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the control of the control of the control one one of the control one one of the control of the c	o the best of my kno he basis of examina manner stated.	owledge, death ation and/or inve	occurred at the tirestigation, in my o	ne, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) and ma date and place, a	nner as stated. and due to the c	ause(s)
	Tot withi	Σ	29b. Signature and title of certifier	dent		29c. Licens	e number	5	Septem	Kee 11, 2	
 -	6			cause of death (Iter	m 23a) (Type, F	tel m.	Glen	Burnie,	Mb 21	06/	
10	Sta Registr			Registrar's Signa	ture Jos	di)					

			For State Registrar	State of Maryla	nd / Depa <i>Cer</i>	rtment of He tificate of D	alth and M <i>eath</i>			29262	
	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last) Mary Eli	zabeth	Thuma			2. Date of Death Septemb	er ^{2ay} 5, 2 0 0	3. Time of Death 1000 A M	
	Examin		4a. Facility Name (If not institution, give st 204 East Joppa Roa			4b. City, Town, or Li Tousoi			4c. County of Dea		
	Funeral Director		5. Social Security Number UNK 6. Sex	7. Age (In yr	s. last birthday) BB Yrs.		Hours Min.	8. Date of Birth (Month, Pay, N□V • 4 ,	of Birth 9. Birthplace (State or For Country) 4, 1917 Maryland		
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Lo	cation				10d. Inside City Limits	
	e Man	ctor	MD Baltim	ore	Towsor					1 ☐ Yes 2 ☐ No	
	with th	i Dire	10e. Street and Number 204 East Joppa Roa	d		10f. Zip Code 21 28	6	10	g. Citizen of What C	ountry?	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23a or 28a-f ehow empirity or other treumatic event, the Marical Erapidar main the notified at ance.	by Funeral Director		2. Was Decedent Ever in Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates:	'	Nas Decedent of Hisp f Yes, specify Cuban, I □ Yes 2 🗷 No	panic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	te, etc.	
Maryland 21215-0036	within 72 hou ane. then "nature	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occupati kind of work done dur DO NOT use retired) Fice Secre	ring most of works	ng 1	6b. Kind of Business	Vindustry	
d 2	Hygie other	Be Co	17. Father's Name (First, Middle, Last)					(First, Middle, M			
ylar	ould be Menta Merked	ToB			uma		Julia		O'Nie		
Mar	nd 2 sh ith and ith and 27 is m		19a. Informant's Name/Relationship (Type Rev. Clifton Thuma			ng Address <i>(Street an</i> Lng St., L			460	Zip Code)	
Baltimore,	Pages 1 ar		20a. Method of Disposition 1 Burial 2 XCremation 3 Re 4 Donation 5 Other (Specify)	moval from State	illtop 9	natory or other place) Serv Corp	9/7	/06	oc. Location - City o Towson, M	D	
Balti	permit. Departn Imports eny inju		21. Signature of Funeral Service Licens	Tilliam G.		Name and Address			Funeral 21204	Home, Inc.	
8760,	be attending physicien and for use as the burial-transit	dical Examiner	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence of):	Cardiova	(-		Approximate Interval Between Onset and Death	
P.O. Box 68	death certi e attending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	ac. If yes, outcome of preduction of the second of the se	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of do Month	elivery Day Year	
	sign d be	۵	Part II. Other significant conditions con	tributing to death but not	esulting in the u	nderlying cause given	in Part I.			o the cause of death?	
Vital Records,		Completed						24a. Was an autopsy perform 1 □ Yes 2			
Vita	Physicien: Th this certificete ral director, pag	o Be	25. Was case referred to medical examiner? 1X Yes 2 \(\) No	ospital: 1 ☐ Inpatient 2	☐ ER/Outpatier	Other		n (Check only one	nce 6 □Other (Sp	ecify)	
Division of	After After fune	1-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year	28b. Time o	f 28c. Injury a Work?	at	28d. Describe ho		oury)	
Divis	ial or Atte s efter de al Directo ad in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, sti ecify)	reet, factory, office		28f. Location (Str City or Town	eet and Number or F , State)	Rural Route Number,	
	To the Hospital or Attend within 24 hours effer death To the Funeral Director: completely filled in by the	edicai	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my ler: On the basis of exam and manner stated.	knowledge, deat ination and/or in	h occurred at the time vestigation, in my opi	o, date and place, nion, death occurr	and due to the ca red at the time, da	use(s) and manner a ite and place, and di	is stated. e to the cause(s)	
)	Tot withi Tot com	Σ	29b. Signature and title (of certifier	De De	dv	29c. License	number 667	29	ed. Date signed (Mor	nth. Day, Year)	
	H		30. Name and address of person who co	mpleted cause of death (Tr. 1-1	- 11:110	T. Luth	ewille	IS QM.	690	
1	St Regist		31. Date filed (Month, Day, Year) SFP 1 4 2006	32. Registrar's Si	nature						

			For State Registrar	State of Maryl	•	artment of H			giene Reg. No 200	6 29263
	Physici		1. Decedent's Name (First, Middle, Last) O: A R R R R		VA	NLANDI	26-41m	2. Date of De Month SEPTEM	Day Ye	ar 3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give si	reet and number)	V/1	4b. City, Town, or		D-1	4c. County of E	
	Examili	eı	THE JOHN'S HOPISIN		L	BALTIN	MARE	CITY	NA	
	Funeral		5. Social Security Number 6. Sex	7. Age (In)	vrs. last birthday)	If Under 1 Year Months Days		8. Date of Bir (Month, Da	th 9.	Birthplace (State or Foreign Country) Md.
	Director		Usual Residence of Decedent	66				10-10)—I939	
	72 hours after death with the Maryland natural; or theme 23a or 28a-f ehow digal Evantrar must be notified at	5	10a. State 10b. County	100.	City, Town or Lo					10d. Inside City Limits 11 Yes 2 □ No
	the M	ecto	Md. NA		Balt:	10f, Zip Code			10g. Citizen of Wha	
	with Ba or	ă	1813 E. Federal S	treet		2121	3		USA	
	death ms 2	nera		2. Was Decedent Ever i Armed Forces?	n U.S. 13.1	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Specify Yes or No	14. Race - A	American Indian,
9	or the	F.	1 Never Married 2 ☐ Married	1 ☐ Yes 2 ☑ No		ilos, specily cuba 1 □ Yes 21√2 No	Specify:	to rican, etc.)	Specify:	Vhite, etc.
5-0036	ural',	q p	3 Widowed 4 Divorced	Year or Dates:						Black
15	n 72 nat	Completed by Funeral Director	15. Decedent's Educ (Specify only highest grade	completed)	(Give	ient's Usual Occupa kind of work done o DO NOT use retired	turina most of wo	orking	16b. Kind of Busine	ass/industry
2121	iene. r then	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		lical Lab	•		J.H.H	•
	other	Ф	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle	, Maiden Sumame)	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23a or 28a-1 show other traumatic event, in Medical Examinar must be notified at	To B	George	Raymond		rower	Erma		Jackso	
Mar	12 sho		19a. Informant's Name/Relationship (Typ		la i	•			er, City or Town, Sta altimore,	
	1 and 2 Health tem 27 other tr		Henry L. Vanlandi		b. Place of Dispo	sition (Name of	Ţ.	Date Date	20c. Location - City	
nor	ages int of l t: if it		1√2 Burial 2 ☐ Cremation 3 ☐ Re	moval from State	cemetery, crei	natory or other plac	ı	5-06	Randalls	
Baltimore,	permit. Pages 1 an Department of Heal Important: if Item 2 any injury or other once.	1	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License		King Mem	I. PK. Name and Addres	1			LOWIT, FIG.
Ba	permit. Departr Imports any inj		> Blades	Wane	ا سر	.101 E. No	orth Ave	., Balti	.H. East more, Md.	21202
	Physician //Medical physician and physician and physician and the pruari-transit the pruration of the prurat	Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con	ATRY sequence of): ATRY sequence of): ARY	ABRES	5.7	с от гезрпасогу а	11651,	Approximate Interval Between Onset and Death 3 Hours
P.O. Box 68760,	equires that the death certificate be executed sen signed by the attending physicien and tould be detached for use as the burial-transit	Physician/Medical	in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pre 1	Fétal déath 3[of death 5[Ectopic pregnancy Other (specify)			23d. Date of Month	Day Year
	signed bed	ρ	Part II. Other significant conditions con	ributing to death but not	resulting in the u	nderlying cause give	en in Part I.			te to the cause of death?
I Records,	The law r ete hes by page 2 sh	Completed						24a. Was auto perfo 1 Yes	psy prior primed? deat	
/ita	ician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?			Var		ath Check only	one/	
of \	hys this	ို	1 Yes 200 No		2 ER/Outpatier		4 🗀 lauraing		dence 6 Other (Specify)
<u>_</u>	E E	E I	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Yea	r) Intury	Worl	yat k? Yes 2 □ No	20d. Describe	now injury occurred	
Division of Vital	Attending r death. sctor: After by the fune	Certification;	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury -	At home, farm, str					r Rural Route Number,
Ö	at or safter	F	4 Homicide determined	building, etc. (Sp	ecify)			City or To	wn, State)	
	To the Hospital or Attendit within 24 hours after death. To the Funarst Director: Al completely filled in by the fu	edical C	29a. Certifier (Check only one) Certifying Phys	cian: To the best of my er: On the basis of exar and manner stated.	knowledge, deat mination and/or in	n occurred at the tin vestigation, in my o	ne, date and ptace pinion, death occ	e, and due to the curred at the time,	cause(s) and manne date and place, and	or as stated. due to the cause(s)
	vithin o the	Me	29b. Signature and title of certifier			29c. License	e number		29d. Date signed (N	fonth, Day, Year)
			m. Jand	MEDICA	46 00000	RES	- 000	,	SECTEMBE.	R 09 2006
1	1		30. Name and address of person who co	npleted cause of death	(Item 23a) (Type,	Print)		14	1 . 10	21287
2			GIA M. LANDRY, THE	JOHNS HOPKIN	L HOSPITY	7L ,600 2	ONTH WOL	FE STREE	ET BALTIM	2 1287 21287 OCE, MARYLAND
	Sta Regist		31. Date filed (Month, Day, Year) SEP 1 4 20	32. Ragistrar's S	ignature	Carle			,	

DHMH 17 Rev 1/2001

ORIGINAL

		•	1 - For State Registrar	State of Ma	aryland		artmen rtificat			and Me	-	giene Reg. No.	2 n n c	29264
	Physicia	20	1. Decedent's Name (First, Middle, L	ast)						1	2. Date of De Month	ath Day	y Year	3. Time of Death
	/Medic		Emory	Whitney							09/10/	2006		12:00 P M
	Examin	er	4a. Facility Name (If not institution, g				4b. City,	Town, or	Location o	f Death			County of Dea	
2			9000 Briarcroft		io (In ure li	ast birthday)	Laure ff Under		If Under 2	24 Hrs	8. Date of Bin		cince G	eorges thplace (State or Foreign
	Funeral Director		5. Social Security Number 420–44–7727	1 XM 2□F	77	Yrs.	Months		Hours	Min.	(Month, Da 10/20/1	y, Year)	3. O	ountry) MD
			Usual Residence of Decedent								.0/20/1	.520		LID.
	how		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	e Ma	cto	MD Prince G	eorges	Laur	el								1 ☐ Yes 2 ☐ No
	or 2	Director	10e. Street and Number	_			10f. Zip					10g. Citi	izen of What C	ountry?
	s 23s	Funeral	9000 Briarcroft	Lane	Ever in 11 6	12.1	207		nania Orio	nin2 /5000	it. Vec or No		USA 14. Race - Am	orican Indian
	itsm itsm	-nu	11. Marital Status 1 Never Married 2 Married	Armed Forces?		5. 13.	If Yes, spe	cify Cubar	n, Mexican	, Puerto R	ify Yes or No ican, etc.)		Black, Whi	
99	urs al	by	3 ₩idowed 4 Divorced	If Yes, Give Year or Dates:			1 🗆 Yes	2₹ No	Specify:				Specify: W	hite
Ö	72 ho	Completed	15. Decedent's (Specify only highest g			16a. Dece	dent's Usua kind of wo			of working	n.	16b. Ki	nd of Business	/Industry
2	ithin Jan Mac	npie	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life.	DO NOT u	se retired)	aring most	or working	9	Drvde	an (Thomas)	l=
2	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or itams 23e or 28e-f show avent. The Medical Examiner must be notified at		7th 17. Father's Name (First, Middle, Las			Mechar	ilC		19 Motho	r's Alama	(First, Middle,		er Truci	<u> </u>
anc	t be find he of ot	Be	William A. Whitn	•					Mabe:			Maluen	Sumame)	
Maryland 21215-0036	should ind Men ind Men inmarke	ဥ	19a. Informant's Name/Relationship	- -		19b. Mailir	ng Address					ar. City o	r Town, State,	Zip Code)
₹	and 2 s salth an n 27 ls ier trau		Kathi Whitehead				-				rel, M			
ē,	s 1 ar f Hea item othe		20a. Method of Disposition	·	20b. PI	ace of Dispo	sition (Nar	me of		Da	-		cation - City o	Town, State
Ë	Pages nent of int: If it iry or o		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			wridge				9/15/	2006	Elk	ride,	MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or itsms 23a or 28a-f ahow any futury or other traumatic avent. The Madical Examiner must be notified at ance.		21. Signature of Funeral Service Lic	ensee	85								t MMP,	
<u>m</u>	89 = 8		1 /hfm	MO	1234	72	250 W	ashir	gton	Blvd	i., Elk	ride	e, MD	21075
	Physician		23a. Part1. Enter the disease, or co shock, or heart faifure. List on fmmediate Cause (Finaf disease or condition	y one cause on each li	ne.	Do not ent					respiratory a	rrest,		Approximate Interval Between Onset and Death
gi.	/Medical Examiner		resulting in death)	Due to (or as			,,,,,	11/00	,,					7,00,2
		er	Sequentially fist conditions, if any, leading to immediate	b. Due to (or as	a consequ	rence of):								
31	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c										
0,2	an an rial-tr		resulting in death) Last	Due to (or as	a consequ	ence of):								
8760,	death certificate be executed e attending physician and od for use as the burial-transit	Physician/Medical	•	d										
9 ×	eath certific attending pl	Мес	fF FEMALE:	202 #	-4		-							
Вох	attend for us	ian	23b. Was decedent pregnant in the past 12 months?	23c. ff yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	death 3[Ectopic pi						23d. Date of de Month	olivery Day Year
P.O.		ıysic	1 Yes 2 No	9 Unknown	t tillio or de	30	_ Other (s)	Decity)						
	law requires that the as been signed by th 2 should be detache	by Ph	Part ff. Other significant conditions	contributing to death b	out not resu	Iting in the u	nderlying o	ause give	n in Part I.		23e. Did t	obacco u	ise contribute l	o the cause of death?
rds	w requires been sign should be										10	Yes 2	□No 3□P	robably 4 Minknown
ပ္သ	aw requ as been 2 shouk	piet									24a. Was		24b. Were a	utopsy findings available
ž	o - o	Completed						_			autor perfo	rmed?	death?	completion of cause of s 2 1 No
ita	Physician: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o	ле)		
<u>></u>	Physic this co	၉	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatie		ER/Outpatier			4 🗆 1401				6 □Other (Sp	ecity)
ū	ing P	:uo	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of fnjury		28c. Injury Work	?		Bd. Describe I	now injur	y occurred	
is:	Attending ir death, ector; After by the fune	icat	2 Accident investigat 3 Suicide 6 Could not	be Ope Place of Inc	iune - At ho	me form str	M (actor		′es 2□f		Rf Location /	Street an	d Number or E	lural Route Number,
Division of Vital Records,	after Direction by	Certification:	4 ☐ Homicide determine	building, et			eel, ractor	y, onice		-	City or To			arar Noute Number,
	To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer		29a. Certifier 1 Certifying	Physician: To the best	of my know	vledge, Justi	h conumed	at the time	e data ani	d plane, ar	nd due to the	causa(s)	and wanner a	s stated
	n 24 h	edical	(Check only 2 Medical Ex	aminer: On the basis o and manner st	f examinat ated.	ion and/or in	vestigation	i, in my op	inion, deat	th occurred	d at the time,	date and	place, and du	e to the cause(s)
	To the within 2 To the complei	5	29b. Signature and title of certifier	. 1			29	c. License	number			29d. Dai	le signed (Mon	th, Day, Year)
)			Man A	M				DZ	499	7			9/11.	106
	10		30. Name and address of person where the street of the str	o completed cause of c	death (Item ミップ	23a) (Type,	Print)	ZAN	E	LAU	REL	MI) Zc	707
4	Sta	te	31. Date filed (Month, Day, Year)	32 Registr	rar's Signa	File /				Ta and				
	Registr	ar	SEP 1 4 2	006 Som	w B	K ASP	344							

			For State Registrar	State of Ma	aryland		artment of H		nd M		giene Reg. No.20	16	29265
			Decedent's Name (First, Middle, Last)			unouto or i	- Journ		2. Date of Dea	ath		3. Time of Death
	Physicia /Medic		Albert Wilford Sr						(09/13/2		Year	1:00 A M
	Examin		4a. Facility Name (If not institution, give			10.	4b. City, Town, or		Death		4c. County of		
			Catonsville Commor 5. Social Security Number 6. Se		e (in yrs. lasi	t hirthday)	Catonsvi.		4 Hrs.	8 Date of Birt	Baltin		place (State or Foreign
	Funeral Director		218-01-2813	RM 2□F	38	Yrs.	Months Days	Hours	Min.	8. Date of Birt (Month, Da) 05/18/1		Cou	ntry)
	D		Usual Residence of Decedent								210		
	show	7	10a. State 10b. County MD Howard		10c. City, T Elkric		cation						10d. Inside City Limits 1 ☐ Yes 2 📆 No
	the M	ecto	10e. Street and Number		DIKLE	age	10f. Zip Code				10g. Citizen of W	hat Cou	
	3e or	Ö	6754 Montgomery Ro	oad			21075				-	SA	of Ea
	death	nera	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S.	13.	Was Decedent of H if Yes, specify Cuba	lispanic Orig	in? (Spe	ecify Yes or No-		- Ameri	can Indian,
98	or Ite	by Funeral Director	1 Never Married 2 Married	1 Tyes 2 7	10		1 ☐ Yes 2 🔯 No	Specify:	, , , ,	, 110411, 010.7	Specify:		
Š	hours turel,	q pa	3 Widowed 4 □ Divorced 15. Decedent's Edi	Year or Dates:		16a Dece	dent's Usual Occup	ation			16b. Kind of Bus		
5	filed within 72 hours after death with the Maryland Hygiene. Ither than "neturel; or Items 23e or 28e-f show ent, the Madical Examinat must be notified at	Completed	(Specify only highest grad	le completed) College (1-4or 5		(Give	kind of work done of DO NOT use retired	during most	of workii	ng	100.11110 01 04		
2	ad with	Com	12	College (1-40) C		onstr	uction W				Constru		on
pu	be file	Be	17. Father's Name (First, Middle, Last)								Maiden Sumame)	
Maryland 21215-0036	hould d Mer marke matic	2	Charles Wilford 19a. Informant's Name/Relationship (7	vne Print)		19h Mailir	ng Address (Street	Mauc			or City or Town 5	State Zi	2 Code)
<u>N</u>	nd 2 s Ith an 27 is r		Elaine Wilford / N				Finnegan						
re,	s 1 ar		20a. Method of Disposition		20b. Plac	e of Dispo	sition (Name of natory or other place			ate	20c. Location - (
<u>E</u>	Pages nent of I ant: if its ury or o		Marial 2 ☐ Cremation 3 ☐ 1 4 ☐ Donation 5 ☐ Other (Specify)			-	Memorial I		9/16,	/2006	Elkridg	e, l	1D 1
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatin and Mental Hygiene. Department of His marked other than "neturel", or teams 23e or 28e-f show importent: If them 27 is marked other than "neturel", or thems 23e or 28e-f show any injury or other treumatic event, the Medical Evantinal must be rediffed at once.		21. Signature of Funeral Service Licens		L234	Ga 72	Name and Address LY L. Kat 250 Washir	ss of Facility ufman ngton	Fune Blvc	eral Ho	me at MM ridge, M	P, I	INC. LO75
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused ne cause on each lin	the death.	Do not ent	er the mode of dyin	g, such as o	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Cong	estic	RI	yeart t	ailu	re				Offiset and Death
	/Medical Examiner		resulting in death)	Due to (of B	a consequer	nce of):							
	(100 I)	er	Sequentially list conditions,	b. Due to or as	a consequer	nce of):						-	
1.	cuted nd ransit	cal Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	с.									
7,092	eath certificate be executed attending physician and for use as the burial-transit	Exa	resulting in death) Last	Due to (or as	a consequer	nce of):							
876				d								-	
89 x	certifi ding use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. Date	of deliv	erv
Вох	that the death cer ed by the attendir detached for use	Iclar	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at]Ectopic pregnancy] Other (s <i>pecify)</i>	<u> </u>			Mon		Day Year
P.O.	at the de by the tached	hys	9 🗌 Unknown	9□ Unknown							1	_	
Ś	es De pe	d by F	Part II. Other significant conditions of April Stell	ntributing to death b	ut not resulti	ng in the u	nderlying cause giv	en in Part I.		23e. Did to			he cause of death? bably 4 □Unknown
Vital Record	sw requir s been s s should	Completed								24a. Was	an 24b. W	ere aut	opsy findings available
Re	The la	mo				-					rmed?	eath?	ompletion of cause of 2 No
ita	cien: ertifica ector,	Be (25. Was case referred to medical examiner?						of Death	(Check only o	ne)		
of \	Physicien: rthis certific ral director,	2	1 ☐ Yes 2 1 HO 27. Manner of Death			VOutpatier 8b. Time o	nt 3 DOA Oth	4 (6)-401			dence 6 Othe		fy)
no	ding F h. After funer	tlon	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	y Year)	Injury	Wor	yat k? Yes 2∐N		zou. Describe i	low injury occurre	u	
Division	Attending or death. ector: After by the fune	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injudicing, et	ury - At home	e, farm, sti	eet, factory, office		2	28f. Location (5 City or Tox	Street and Numbe	r or Rur	al Route Number,
Ö	tal or rs afte el Dir led in	Cert	4 _ Homeda	Dullaling, et	c. (Specify)						,, otate,		
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Exam	ysician: To the best iner: On the basis of and manner st	f examination	edge, deat n and/or in	vestigation, in my o	pinion, deat	d place, a	ed at the time,	date and place, a	nd due t	o the cause(s)
)	To t To t	Σ	29b. Signature and title of certifier	USAL	D. M	no, n	29c. Licens	056 o	414		29d. Date signed 9-14		
	10		30. Name and address of person who d	completed cause of c	leath (Item 2	3a) (Type,	Print)	и		n	-11:		MD 21228
			31. Date filed (Month, Day, Year)	32. Re gistr	ar's Signatur	16	- Fustin	19 HI	veni	MG ! B	altimo	re,	VID 2 1268
	Sta Registr		SEP 1 4 2.0	06 Renew	w B	0	new						

State of Maryland / Department of Health and Mental Hygiene 2006 29266 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 2006 Woodrow Wilson Wright Sr. sen! /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1501 Healthard Kelah Center Hait-end If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Jan. 20, 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Year) Months 1**⊠**M 2□ F 83 Director 218-18-1425 1923 Virginia Usual Residence of Deceden 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Harford Aberdeen 10f. Zio Code 10g. Citizen of What Country? 10e. Street and Number 601 Cornell Street 21001 USA items 23a Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White etc. 2 should be filed within 72 hours after is and Mental Hygiene. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Framer Agriculture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter K. Wright Frances (nmn) Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 sl ment of Health an ant: if item 27 is r Shirley Ziervogel / Daughter 9 Shire Lane, Port Deposit, Maryland 21904 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State permit. Page Depertment of Important: if eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Grdn 9-14-06 Aberdeen, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 10 cardia disease or condition resulting in death) /Medical nsequence of) Examiner S quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a consequence of) Examine ettending physicien and for use es the buriel-transit Due to (or as a consequence of) 68760 The law requires that the death certificate be Physician/Medical IF FEMALE Box 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown signed by Ω 23e. Did tobacco use contribute to the cause of death? Part If, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 →NO 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificete has autopsy performed? 1 ☐ Yes 2 No Vital 25. Was case referred to medical funeral director. 26. Place of Seth Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manuar of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ò To the Hospitel o within 24 hours at To the Funerel D 29a. Certifier Certifying Physician: Tu the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mariner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and filte of 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who compl (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 25 46 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 2006 29267 1 - For Stata Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2006 Sept 11, FRANCES MERLE YOUNG 7:15 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner PICKERSGILL Towson Baltimore County | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept 28 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year) Months 1 ☐ M 2 💢 F Yrs. 1910 Massachusetts Director 212-32-1012 Usual Residence of Decedent 10c. City. Town or Location 10a State 10b County 10d. Inside City Limits other than "natural", or items 23s or 28s-f show sent, the Madical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director Baltimore County Maryland Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21204 USA 615 Chestnut Avenue by Funerai filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Christian Education and Elementary/Secondary (0-12) College (1-4or 5+) Executive Director 5+ Lay Ministry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be fil ment of Health and Mental H tant: if item 27 is marked oth jury or other traumatic even Clara Susanna Jones ٩ Albert Edwin Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Nephew) 13070 West Bluemound Rd, #311, Rev. Dr. Peter F. Arverdson Elm Grove, WI 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or ang. Green Mount Crematory 9/14/2006 Baltimore, Maryland 21. Signation of Fundal S. Relicon ee Martin D. Lawson Martin D. Lawson

Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Road, Baltimore, Maryland 21212

23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approx Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) coliti is chemic Physician weeks /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ 1 Yes 2 TNo 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural s after decail and in a safe of the form o 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 1)25205 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ale Charles St. Balts. Md BMG 6701 31. Date filed (Month 2006 32 Registrar's Signature State Registrar

			For Stata Ragistrar	State of	Maryland		artment rtificate						2006	29	268
	Physicia /Medic		1. Decedent's Name (First, Middle FREDERICI	Last) < C. ZI	ELIN	JSK1					2. Date of De Month	Day	year 0 2306	3. Time of 9 ' 15	Death ·
	Examin		4a. Facility Name (If not institution,	, Ross	VILLE			SED	ALE			C.		MORE	
	Funeral Director		5. Social Security Number 219306443 Usual Residence of Decedent	6. Sex 1 X M 2 ☐ F	7. Age (In yrs. la		If Under 1 Months		If Under Hours	Min.	8. Date of Bir (Month, Da 10/23	тп 19, Year) 1 / 19	34 MAR	nplace (State o untry) YLAND	r r-oreign
	n the Marylend r 28a-f show	tor	10a. State 10b. County	TIMORE		SEDAL								10d. Inside Ci 1 ☐ Yes	
30/01/6	h with the 23a or 28a	al Direc	10e. Street and Number 8011 SAGRAMO	ORE ROAD		•	10f. Zip (212	37				izen of What Co SA	untry?	
	within 72 hours after death with the Marylend ane. than "naturel", or items 23a or 28a-f show ha Medical Examinat must be confilled at	To Be Completed by Funeral Director	11. Marital Status 1 Never Married Marri 3 Widowed 4 Divorced	Armed For	24≦No e		Was Decede If Yes, specin		spanic Ori n, Mexicar Specify:		cify Yes or No Rican, etc.)	0-	14. Race - Ame Black, White Specify: W		
n ch	filed within 72 ho Hygiene. other than "naturent, Ine Medical.	ompleted	15. Decedent (Specify only highes Elementary/Secondary (0-12)	s Education t grade completed) College (1-4	-4or 5+)	(Give life.	dent's Usual kind of work DO NOT use	k done o e retired,	uring mos				ind of Business/	ŕ	
Feederich	d is b	o Be C	17. Father's Name (First, Middle, STANLEY W.	ZIELII	NSKI					er's Name NDA	(First, Middle	, Maiden PYZ			
् ति Mary	12 shoth and 7 is m		19a. Informant's Name/Relations! MARIE M. ZIEI		IFE						I Route Numb		nr Town, State, Z	Tip Code) 21237	
Lyu, more,	of H of H fite		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (S)	3 Removal from S	20b. Pi	lace of Dispo emetery, crei TRO C	osition (Name matory or oth CREMA!	e of her place TOR	₉₎ Y 9	/14/	ate '06	BAL!	cation - City or TIMORE	Town, State	
Bar	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service	icepsee									ALE FUI	NERAL MD 21	
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sion o	tending PI leath. tor: After th	Certification:	27. Manner of Death 1	gation	of Injury th, Day Year)	28b. Time o Injury	М		rat k? Yes 2□	No	28d. Describe				
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	the Hosp in 24 ho the Fune	Medical	(Check only 2 Medical one)				nvestigation,	in my o	oinion, dea			, date and	d place, and due	to the cause(s	;)
	To To To	2	29b. Signature and title of certifie	Awnd					6 / 6 / 2	78	7		te signed (Monti		106.
	Ve		30. Name and address of person LOPHINE OF	RI-AWUAH,	, 9106	PHILA	DELPI	HIA	RD, S	TE 2	08, BI	7671	MORE S	11237	
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			State of Maryland / De 1- State Amend item # 28 b, perME, G859,9/16/06	epartment of Health and Mertificate of Death		2006	29269
	Physicia	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al :	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	8 2	4c. County of Death	1505 M
	Examin	er	UMMC-Shock Trauma	Baltimore		Baltimor	re City
	Funeral Director		5. Social Security Number 6. Sex 1 7. Age (In yrs. last birtho	Months Days Hours Min.	8. Date of Birth (Month, Day, y June 15, 1	9. Birth Cou New	place (State or Foreign ntry) York
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of	or Location			10d. Inside City Limits
	a-f aho	ctor	Maryland Montgomery Silver	Spring			1 ☐ Yes 2 No
	deeth with the Maryland ime 23e or 28e-f ahow ir must be notified at	al Dire	3112 Gracefield Road, #313	10f. Zip Code 20904	10g	United St	
5-0036	or Its	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Spiff Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify:	
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Maryland	nd 2 should be lith and Mentel 27 is marked of r treumatic ave	-		Mailing Address (Street and Number or Run 2 Gracefield Road,#.			
Baltimore,	permit. Peges 1 and 2 should be filed within Depertment of Heelth and Mentel Hyglene. Importants if Item 27 is marked other then any injury or other treumetic event, Insuppose.			representation (Name of crematory or other place) litan Crematory 8/24		c. Location - City or T lexandria,	
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a	w requires thet the bean signed by should be detection.		Part II. Other significant conditions contributing to death but not resulting in the Traumatre Fall with	he underlying cause given in Part I.	23e. Did toba 1 ☐ Yes	cco use contribute lo 2 No 3 □ Pro	
Vital Records,		Completed by			24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of 250 No
Viita	Attanding Physician: Th r death. actor: Atter this cartificate by the funeral director, peg	Be	25. Was case referred to medical examiner? Hospital:	Othor	th (Check only one)		
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Divi	or Attancater death Diractor:	ertifi	4 Homicide determined building, etc. (Specify)		281. Location (Stre City or Town, 3112 Grace		al House Number, Silver Spring
_	Hospita 4 hours Funeral	edicai C	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and place,	and due to the cau	ise(s) and manner as	stated.MD Zoo
	To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month	Day, Year)
	3		PARKH, MI)		9	24/06	5
			30. Name and address of person who completed cause of death (Item 23a) (T Stylkic Packet MD — Mary an	ype, Print) and Shorele Transam	h Craf	er - 2	eltimine mo
3	Sta	ite	31. Date filed (Month, Day, Year) 31. Registrar's Signature	nd Shock Traum	u com	12	THE PARTY OF THE
	Regist	ar	AUG 3 0 2006 Boom B. A	75-62			

		1	For State Registrar AMEND#23a(b)perN	State of Maryland / [F8/30/06, BW, McCo		tment of He ficate of D			ene g. No. 20	06 29	270
	Physicia		1. Decedent's Name (First, Middle, Last)			Anderson		2. Date of Death August	_	3. Time of 0 9:30	
À	/Medic Examin	al -	George 4a. Facility Name (If not institution, give sti	reet and number)		4b. City, Town, or		riagabe	4c. County of	of Death	
	LXGIIIII		Renaissance Gardens at I		-tt \	Silver	Spring If Under 24 Hrs.	9 Date of Birth	Prince	George's 9. Birthplace (State or	Foreign
	Funeral Director		5. Social Security Number 6. Sex 119-01-6940	M 2□F 7. Age (In yrs. last bir		Months Days	Hours Min.	8. Date of Birth (Month, Day, Sept. 15	,1914	Buffalo, N	Y
	o .	- 1	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	m or Loca	tion				10d. Inside City	y Limits
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	within 72 hours after deeth with the Maryland iene. Then "naturel", or Itema 23e or 28e-f ehow the Medical Examb at must be notified at	Directo	10e. Street and Number 3112 Gracefield Ro	nad. #313		10f. Zip Code 20904		10	og. Citizen of W	hat Country? States	
	deeth me 23	Funerai		2. Was Decedent Ever in U.S. Armed Forces?	13. Wa	as Decedent of His	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No-		- American Indian, , White, etc.	
20	hours after tural', or Ite al Exercit	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1X Yes 2 No 1f Yes, Give Year or Dates: WWII		⊒Yes 2⊡xNo	Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify:	White	
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7	within 72 ene. then "nai	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) _	lucat		uring most of work		Educat	i.on	
7 0	illed v Hygie other i	Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Nam		laiden Sumame	Pauldi	na
ylar	ould be Menta varked vatic ev	ToE	Gustav Edmond		nder		Harriet		City of Tourn	Fauldi State, Zip Code)262	
Z	d 2 sh Ith and 27 is m r traum		19a. Informant's Name/Relationship (Typ Lois A. Ezell -daug							st Virgini	
ore,	of Hea of Hea fitem		20a. Method of Disposition 1 □ Burial 2 ☐ Cremation 3 □ Re	cemete	ıry, crema	tion (Name of story or other place	a) !			City or Town, State	
Baltimore	permit. Pages Department of Important: If it eny injury or o		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	Metrop		44.0				ria, Virgi	nıa
g R	Departit. Departit Imports eny inj	ç ü	Dorald V. E	Borgward	Dor 440	nald V. 1)O Powder	sorgwardt Mill Ro	Huneral ad Belts	ville,	PA Maryland 2	0705
ı			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations hat caused the death. Do e cause on each line.	•	,	1	1		Approximate Interval Betw Onset and D	veen
1	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a los once	of):	igestr	c- News	+ Jail		ndnu	onths
	Examiner		Sequentially list conditions, b.	Coronary Arte	ry D	isease				≥ 2 mor	nths
	uted 1 ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequence	01):						
Ď,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a consequence	of):						
28760	the part	dicai	d.								
X	deati certific e attending p ed for use as	Physician/Me	23b. was decedent pregnant	3c. If yes, outcome of pregnancy 1□Live birth 2□Fetal deatl	h 3⊡E	Ectopic pregnancy			23d. Date	e of delivery	ear
о. В	0 0 0	ysici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of death 9☐ Unknown	5 🗆 (Other (specify)					
ď.	Attending Physician: The law requires that the rideath. cleath. sctor: After this certificate has been signed by the tuneral director, page 2 should be delacheby the funeral director, page 2 should be delached.	by Ph	Part II. Other significant conditions con	tributing to death but not resulting	in the und	derlying cause give	en in Part I.			ibute to the cause of d	
ord	w require been si should b	eted						1 ☐ Ye		3 Probably 4 U	
Rec	helaw ehast age 2 s	Completed						autops	ned? p	rior to completion of calleath?	ause of
/ita	cian:] ertifical sctor, p	BeC	25. Was case referred to medical examiner?					th (Check only on	· · · · · · · · · · · · · · · · · · ·	Asau	who d
6	Physic rthis c aral dire	5	1 ☐ Yes 2 No	ospital: 1 Inpatient 2 ER/O 28a. Date of Injury (Month, Day Year) 28b.	Time of	3□ DOA Othe	at	ome 5 Reside		er (Specify)	7
ion	ending sath. or: Afte he fune	ation	1 Natural 5 Pending 2 Accident investigation		Injury		Yes 2 □ No				
Division of Vital Records,	after de Direct	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, 1 building, etc. (Specify)	farm, stre	et, factory, office		28f. Location (St City or Town		er or Rural Route Num	ber,
_	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	(Check only 2 Medical Examin	licien: To the best of my knowledger: On the basis of examination a)
	To the within 2. To the complet	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. Licenso	e number	2	9d. Date signed	(Month, Day, Year)	
•	6		Javen M	estiff		D004	3375		8/28/	04	
			30. Name and address of person who co	mpleted cause of death (Item 233		ad S	ilver S	rina.	MDZ2	904	
		ate	31. Date filed (Month, Day, Year)	32. Degistrar's Signature	Sol	Me					
	Regist	leli	AUG 3 0 20	Element Jo	1						

Please Type or Print in Black Indelible Ink

William Atlee Ar		1- For State	State of M	aryland /	Departm Certifica			nd Ment	al Hygiene	2	2006 292
Physicia		Registrar 1. Decedent's Name (Firs	st, Middle, Last)				-		2 Date of D	eath	3 Time of Death
Medical Exami		William At	lee Armour	111					Month Septem	ber 8, 2006 Ye	2303 hrs
De la companya della companya della companya de la companya della		4a Facility Name (if not i	nstitution, give street	and number)		4	b. City, Town, o	r Location of	Death	4c. County	of Death
		Union Hospital		17.4	(1) II I	la de la	Elkton	Light	out. In part of	Cecil	
Funeral Director		5. Social Security Number			(In yrs last birt	(nday)	If Under 1 Ye Months Da		Min		Y) 9. Birthplace (State or Foreign
Director		215-74-822		F	46	Yrs			Nov.	11,1959	Country) Marylan
any	H	Usual Residence of Dece 10a State 10b. (County		10c. City, Town	or Location	on .				10d. Inside City Limits
ž		MD	Cecil		Elkto	11/2					1 Yes 2 X No
arylar	Director	10e Street and Number	CECKL	1	LLIELU	1	10f. Zip Code			10g. Citizen of W	hat Country?
the Ma or 2	ä	1824 Blue	Ball Road				21921			USA	
D 21215-0036 should be filted within 72 hours after death with the Maryland and Mental Hygiene is 78 narked offer than "natural", or items 23a or 28a-f show ratic event, the Medical Examiner must be notified at once.	uneral	11. Marital Status	12. W	as Decedent	Ever in U.S				n? (Specify Yes or Puerto Rican, etc.)	No- 14 Race	e - American Indian, Black,
death or ite	Ë	1 X Never Married 2	1	Yes 2	X No	1116	s, specily cuba	in, iviexican,	ruerto Ricari, etc.)	VVIII	te, etc.
after ral",	by F	3 Widowed 4	Divorced If Yes, or Date	S.			Yes 2 X N			Specify:	White
hours 'natu		15. Decedent's Education Elementary/Secondary		est grade com llege (1-4 or 5			s Usual Occupa st of working life		ind of work done use retired)	16b Kind of Bi	usiness/Industry
36 hin 72 than '	be		7 (0-12)	nege (1-4-01-0		Land	scaper			Lands	caping
5-0036 led within 7 Hygiene tother than	Completed	10 17. Father's Name (First,	Middle, Last)			Lunu	scaper	18.Mother's	Name (First, Middle	e, Maiden Surname	e)
215 be file mtal H rked o	Be (William At	lee Armow	ı. Jr.				Frav	ices Oleta	ı Gouah	
21) nould the id Men is mar tic eve	은	19a Informant's Name/R	elationship (Type, Pr	int)	191	b. Mailing	Address (Stre	et and Numb	per or Rural Route N	lumber, City or Tov	vn, State, Zip Code)
MD nd 2 sho alth and m 27 is		James Thom	<u>as Armour</u>	brothe	<u>r </u>	203	Razor S	trap 1	Road, Nora	th East,	MD 21901 - City or Town, State
ore, slar of Hez If ite		20a Method of Disposition 1 X Burial 2 Cr		noval from Sta		of Dispositions of the	tion (Name of co er place)	emetery,	Date	200 Location	- City or Town, State
altimore mit Pages I r ppartment of H pportant: If it inty or other		4 Donation 5 0	Other Specify			zer	Cemeter	y	09-13-200	16 Rising	Sun, MD
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after begarment of Health and Mental Hygiers. Important: If them 27 is marked other than "natural", in increase, the Medical Examiner.		21. Signature of Funeral	1.	/		22. N	ame and Addres	ss of Facility	R.T. Fow	id Funera	l Home, P.A.
		23a Part I. Enter the dise	age or complication	e that caused	the death. Do no	ot enter th	11 S. Q	ueen S	st., Risi	ig Sun, N	1D 21911 eart Approximate Interva
Physician. /Medical	2	failure. List only one	e cause on each line						rulac or respiratory	arrest, stock, or the	Between Onset and Death
xaminer		Immediate use (Final or condition resulting in o		(or as a conse	erotic ca	rdiova	ascular d	1sease			Dearri
			b	(01 43 4 001130	querice or,						
	Jer	Sequentially list condition if any, leading to immediate	ate Due to	(or as a conse	quence of):						
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'60, rate be ohysicia te buriz		IF FEMALE:	23c.		ne of pregnancy	, peri	L,gco,	10/1//0	0 11	23d Date o	f delivery
Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death To the Functal Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the t	sician/M	23b. Was decedent pregr past 12 months?	nant in the	Live birth	time of death		al death 3	Ectopic	pregnancy	Month	Day Year
Box e death c the atten	/sic	1 Yes 2 No 9	Unknown 9	Unknown	time or death	5 Oth	er (Specify)				
O. Be nat the detached	Phy	Part II. Other significant	t conditions contrib		but not resultin	ig in the u	nderlying cause	given in Par	tl 23e Di	d tobacco use cont	ribute to the cause of death?
P.(es tha igned	l by								1 📑	res 2 No 3	Probably 4 🗸 Unknown
of Vital Records, g. Physician: The law require ther this certificate has been si neral director, page 2 should b	Completed								24a W		Were autopsy findings available prior to completion of cause of
e law e has	mpl								ре	rformed?	death?
I Re		25 Was case referred to	medical				26.Plac	ce of Death (Check only one)	s 2 No	Yes 2 No
Vita ysicial his cer direct	o Be	examiner?	No	1 Inpatie	nt 2 🗸 ER/0	utpatient		Othor	Nursing Home 5	Residence 6	Other:
n of Vi ding Physi After this funeral dir		27. Manner of Death		a. Date of Inju (Month, Day,Y	ry 28b.	Time of Ir	jury 28c. Inj	ury at Work?	28d Describ	e how injury occur	red
On endir sath or: A	ţi	1 Anatural 5	Pending	(WIOTHIT, Day, 11	cary		1	Yes 2	No		
Division tal or Attendi rs after death at Director: A	ifica	2 Accident 3 Suicide 6	Investigation Could not be	Be. Place of Inj	jury - At home, fa	arm, stree	t, factory, office	building etc		(Street and Numb , State)	per or Rural Route Number, City
Division Hospital or Attent 24 hours after death Funcral Director: stely filled in by the	Certification:	4 Homicide	determined (S	Specify)					OI TOWI	i, State)	
e Hos 24 ho e Fim		(Oncordon)	fying Physician: To		_						
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	Σ	29b. Signature and title of	Certiner	11	-,			nse number			ned (Month, Day, Year)
		4	WI.	M			0.0	i.M.E.		Septembe	n 9, 2000
		30 Name and address o Jack Titus MD.	f person who comple Deputy Chief			11 Pan	n Street, Ba	altimore N	MD 21201		
	tota										
Regis	tate trar	0.00	2006	aug 1	r's Signature	ule					

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 10:00 AM 26, AUGUST 2006 PASQUALINA LEONE BENNETT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Country 1 ☐ M 2 🗓 F Yrs 93 NEW YORK 577-07-3229 FEBRUARY 22, 1913 Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State items 23a or 28e-f ehow 1 ☐ Yes 2 No Director MARYLAND. MONTGOMERY SILVER SPRING 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number with 20901 919 BENSON TERRACE U.S.A. deeth Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ঐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: þ 3 X Widowed 4 □ Divorced WHITE 'netural' Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 HOMEMAKER OWN HOME permit. Peges 1 and 2 should be filed Department of Health and Mental Hyg Important: if item 27 ie marked other any injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 CESIDIO LEONE LUCIA RUFO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 919 BENSON TERRACE, SILVER SPRING, MARYLAND 20901 PATRICIA B. GRAHAM - DAUGHTER 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FORT LINCOLN CEMETERY 8/31/2006 BRENTWOOD, MARYLAND 21. Signature of Funeral Service License 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MARYLAND 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Inset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) burial-transit The law requires that the death certificate be executed Exami (or as a consequence of) nding physician Box 68760 Physician/Medical the IF FEMALE: If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ۾ 2 No 3 Probably 4 Unknown 1 🗌 Yes Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 22 No certificate has autopsy 2/2/No 1 Yes Hospital or Attending Physician: funeral director 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑(No ဥ 2 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date Injury (Month, Day Year) 27. Manner of Death 28c. 28d. Describe how injury occurred Certification: Injury at Work? After Matural 5 Pending nours after death. neral Director: Aft filled in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) egistrar's Signature State 2006 30 AUG Registrar

			For Stete Registrar	State o	f Marylar	id / Depa <i>Cei</i>	artmer <i>rtificat</i>	t of He e of D	ealth and <i>eath</i>	Mental Hy	/giene Reg. No	20	06	29273
	Dhusiair	200	1. Decedent's Name (First, Middle, La	st)						2. Date of Di Month	eath Da	у	Year	3. Time of Death
	Physicia /Medic		Vienna Wierimaa Bow							August	-	006		10:45 p M
	Examin	er	4a. Facility Name (If not institution, giv	e street and nur	nber)		4b. City	Town, or l	ocation of Dea	th	40	. County	of Death	
Ī	Funeral Director		Holy Cross Hospital 5. Social Security Number 6. S 220-58-5541	ex □ M 2 🟋	7. Age (In yrs. 88	last birthday) Yrs.	Silv If Unde Months		ing If Under 24 Hr Hours Min	s. 8. Date of Bi (Month, D	ay, Year)		Cou	ntgomery blace (State or Foreign ntry) Minnesota
			Usual Residence of Decedent							THY 12,	1310			
rylan	how	L	10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	10d. Inside City Limits 1 ☐ Yes �� No
M.	Sa-f	Director	Maryland Montgomery					ington						
Aith t	2 E	Dire	10e. Street and Number					Code			10 g . Ci	tizen of V		ntry?
eath	38 234 Talest	erai	11110 Mitscher Street		dent Ever in U	.S. 13 V		20895	panic Origin? (Specify Yes or N	0-		SA e - Americ	can Indian,
rs after d	and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f ahow aumatic event. <u>The Medical Examinat must be notified at</u>	by Funerai	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Fo 1 Tes If Yes, Giv Year or D	rces? 2 👿 No 'e	1	fYes, spe 1 ☐ Yes	cify Cuban	, Mexican, Puè Specify:	rto Rican, etc.)		Blac	k, White, : Whit	etc.
2 Por	atura ical E		15. Decedent's E	ducation		16a. Deced	dent's Usu	al Occupat	ion	od in a	16b. K	and of Bu	siness/In	dustry
thio 7	Med "n	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1	-4or 5+)	life. L	DO NOT i	se retired)	ring most of w	onking				
1 8 P	ygien trat	Con	12				Reta	il Sal			<u> </u>		Reta	i1
3 E	od off	0	17. Father's Name (First, Middle, Last)					18. Mother's Na	me (First, Middle			e)	
y v	1 Mer narke	욘	Henry Wierimaa 19a. Informant's Name/Relationship (Tuna (Print)		10h Mailia	- Add-00	/Stroot or	ad Number or F	Olga Wier			State Zir	- Codol
42 st	Department of Health and Mental Important: If Item 27 is marked of any injury or other traumatic evence.		Patricia Merriman/				-			BN, Oak Pa) CODE)
1 an	tem 2		20a. Method of Disposition		20b. F	Place of Dispo	sition (Na	me of	A110	pust 30,	20c. L	ocation -	City or To	own, State
Page	Ga it g		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		State	ropolita	-		1	2006	A	lexan	dria,	Virginia
	partm porta y inju		21. Signature of Funeral Service Lice	1588		Fi	ancis	nd-Address	Minsty Fur	neral Home	Inc.			
3 8	8 5 8		Aams 58	Dody	P/	50	00 Uni	versit	y Blvd, V	V, Silver	Sprin	g, MD	2090	1
			23a. Part1. Buter the disease, or com shock, or heart failure. List only	plications that o	aused the deat ach line.	h. Do not ent	er the mo	de of dying,	such as cardia	ac or respiratory a	arrest,			Approximate Interval Between Onset and Death
	nysician Medical		Immediate Cause (Final disease or condition resulting in death)	a Sepsis	or as a consec	mence of/:								Oriset and Death
Ε	xaminer		1	Due 10 1	01 43 4 0011300	derice ory.								
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cate	physiclan and s the burial-transit	dicai	•	_d						·				
Certifi	ging se as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out								23d. Dat	e of deliv	erv
Physician: The faw requires that the death certif	igned by the attending be detached for use as	Physician/M	in the past 12 months?	4☐ Pregn	irth 2 ☐ Feta ant at time of c		Ectopic p Other (s					Moi		Day Year
) ğ	by the	hys	9 Unknown	9□ Unkn	own									
o, -	gned be de	ру Р	Part II. Other significant conditions	contributing to de	eath but not res	ulting in the u	nderlying	cause giver	n in Part I.					he cause of death?
in be	been si		Dehydration, Metabol	Lic Acidos	sis, Diar	rhea –				1 🗆	Yes 2	X□ No	3 Prot	bably 4 □Unknown
i k	as be	Completed								24a. Wa auto	DDSV	24b. V	Vere auto	opsy findings available impletion of cause of
	cate h	Con								pert 1 ☐ Yes	ormed?		Yes	2 No
V : Ke	h. After this certificate has funeral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:				Othor		eath (Check only				
5 &	r this raldii	. To	1 ☐ Yes 2 🔀 No 27. Manner of Death	1 (28)		ER/Outpatien		JA	4 Unursing	Home 5 ☐ Res 28d. Describe				(y)
	th. : Afte	tion	1X Natural 5 ☐ Pending 2 ☐ Accident investigatio		of Injury th, Day Year)	Injury	м	28c, Injury : Work? 1 □ Y	es 2□No		,	,		
or Atter	after death Director: I in by the	Certification:	3 Suicide 6 Could not be determined	289. Place	of Injury - At h ng, etc. (Speci	ome, farm, str (y)	eet, factor	y, office		28f. Location City or To			er or Run	al Route Number,
- Hospite	within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier 1 Certifying Pl (Check only one)	miner: On the b	best of my kno asis of examina ner stated.	owledge, death ation and/or in	h occurred vestigation	at the time	a, date and place nion, death occ	ce, and due to the curred at the time	cause(s) and ma d place, a	nner as s and due t	stated. o the cause(s)
Toth	within To the compl	Me	29b. Signature and title of certifier	P			29	c. License			29d. Da	-		Day, Year)
			1	te	MA			D06:	334			Augus	st 29,	, 2006
-			30. Name and address of person who Irina Ruban, M.D	completed caus				orina.	MD 20910)				
	Sta	te	31. Date filed (Month, Day, Year)	32.	B gistrar's Signa		10	9						
	Registr		Aug 30	2006	P. R. 15 A	19. GH								

			1 - For State Registrar	te of Marylan		artment <i>tificate</i>					giene Reg. No. 2 (006	29274
Ī	Physici	an	Decedent's Name (First, Middle, Last) Trical at	T Dt						2. Date of Dea Month	Day	Year	3. Time of Death
*	/Medic Examin	al	4a. Facility Name (If not institution, give street a Saint Joseph Med	Irene Burt nd number) ical Cent		4b. City, T	own, or l			AUGUST n	4c. Count	2006 y of Death Balt	
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Months		If Under	Min	8. Date of Birt (Month, Da July 16	v. Year)	9. Birth Cou	place (State or Foreign intry) Maryland
	Maryland -f show	tor	Usual Residence of Decedent	10c. City	y, Town or Lo		avre	de G	Grace)			10d. Inside City Limits 1 Yes 2 No
	a or 28a	i Direc	10e. Street and Number 653 Franklin Street	44.		10f. Zip (Code	21	078		10g. Citizen of	What Cou	•
920	72 hours after death with the Maryland Insture!; or iteme 23e or 28e-f show diget Exercities! Secribilised at	by Funeral Director	1 Never Married 2 Married 1 If N	s Decedent Ever in U. ned Forces?]Yes 2 No es, Give ar or Dates:		Was Decede f Yes, special		panic Orig , Mexican Specify:		ecify Yes or No- Rican, etc.)	- 14. Ra Bla Speci	ck, White,	ican Indian, , etc. White
21215-0036	within sne. then	Completed	15. Decedent's Education (Specify only highest grade comp Elementary/Secondary (0-12) Nine Years	leted)	16a. Deced (Give life. L	lent's Usual kind of work DO NOT use Home	done du retired)	ıring mosi	t of workii	ng	16b. Kind of I		ndustry Residence
Maryland ?	should be filed and Mental Hygie marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last) Harry E. R	ale, Sr.				18. Mothe		(First, Middle, Florenc		me)	
, Mar	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Pri Cleo C. Ward-Mikus	Daughter)	100 0	herry	Lan			/Route Numbe			p Code) 1903
Baltimore,	Se to L		20a. Method of Disposition 1 🛣 Burial 2 □ Cremation 3 □ Remova 4 □ Donation 5 □ Other (Specify)	I from State	lace of Dispo emetery, cren ford Men	natory or oth	er place	· .	۵ 09/0	1/06	Aberde		own, State aryland
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	C		30. Name and address of person who complete LINDA BARR, M.D.,	d cause of death (Item 7601 OSL		·	րլույս	รตพ	MOE	RYLAND	21204	U	
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	Sta Registr		31. Date liled (Month, Day, Year AUG 3 0		16 8	Registrar's S	gnature	April	who		, -							Ī

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State of Maryland / Department of Health and Mental Hygiene, 29277 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** September 6 0530 Peter Boinovych /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Ceci1 Laurelwood Care Center **Elkton** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV 3, 191 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Months Days Hours 1 MM 2□ F Yrs 1916 Pennsylvania 89 Director 222-03-3307 Usual Residence of Decedent e filed within 72 hours after death with the Maryland at Hygiene. other then "natural", or Iteme 23a or 28s-1 ehnw 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State r then "natural", or Iteme 23a or 28e-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 📆 No Directo E1kton Maryland Ceci1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 220 Melbourne Boulevard 21921 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1777 T Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Armed Forces? WWII

1 Wes 2 No and
If Yes Give and
Year or Dates: Korea 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: þ 3 ♥ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Farmer Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H lant: If Item 27 Is marked ot Catherine Andrushession Nicholas Boinovych 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles M. Dennis, Jr./Nephew 810 Frenchtown Road, Elkton, Maryland 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State September ö X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. 8, 2006 Elkton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Elkton Cemetery 21. Signature of Funeral Service Licensee Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 Mister Micks risman 23a. Part Is Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine pulmely dea Division of Vital Records, P.O. Box 68760, the burial-transit Due to (or as a consequence of) Physician/Medical attending phase to IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month signed by the at d be detached for 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ 📉 3 Probably 4 Unknown should 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 XV0 1 Yes director Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: ဥ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this funeral of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death М investigation ector: A 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funeral Direct completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ceel NR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #CU 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 Registrar 4

		1 - For State Registrar		State	of Mary	land / Dep Ce	artme ertifica	ent of H ate of L	ealth an Death	d Me	ntal Hygi	ene g. No.	006	29278
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		9220 SADI		S. Sex	7. Age (In	yrs. last birthday	/) If Uno	LaPL der 1 Year	ATA If Under 24 I	Hrs. g	. Date of Birth	L	CHARLES	place (State or Foreign
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hygiene. Important: If the MZ is marked other then "natural", or items 23a or 28a-f show eny injury or other treumatic event, the Medical Examinar must be notified at once.	era	11. Marital Status		12. Was De	cedent Ever	in U.S. 13	. Was De		spanic Origin?	? (Specif	y Yes or No-		Race - Americ	
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To the Hospital or Attending Physician: The law requires that the death certifications after discussions and the death certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical C	29a. Certifier 1 🔀 (Check only 2 🗌 one)	Certifying Medical Ex	Physicien: To the	e best of my basis of exar	r knowledge, dea mination and/or i	th occurrenvestigation	ed at the tim on, in my op	e, date and pl inion, death o	lace, and	d due to the car at the time, da	use(s) an te and pla	d manner as s ace, and due to	tated. o the cause(s)
Fo the	Me	29b. Signature and title	of certifier				2	29c. License	number		29	d. Date s	igned (Month,	Day, Year)
7	W	> /	Jah	- Mati	n r	10		D5	2289	9		0	8/29/	2006
1		30. Name and address of	f person w	no completed cau	ise of death	(Item 23a) (Type	, Print)							
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Sta Registr		31. Date filed (Month, Da			Aggistrar's S	Signature	asoli .	1						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** August 23, 2006 Anna G. Chillemi /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5209 Paducah Road College Park Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. July 23, 1926 9. Birthplace (State or Foreign Country) New Jersey 5, Social Security Number 146-14-4014 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F Vrs Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits rel', or items 23a or 28a-f show Examiner must be notified at Maryland|Prince George's College Park 1 Yes 2 No Directo 10e. Street and Number 5209 Paducah Road 10g. Citizen of What Country? United States 10f. Zip Code 20740 Pages 1 and 2 should be filed within 72 hours after death vant of Heelih and Mental Hyglene.
ans: If item 27 is marked other then "raturel", or Items 23, my or other fraumatic event, Ite Medical Exertlest must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Giammarella Joseph Angelina Vitale ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph J. Chillemi, Sr. -husband 5209 Paducah Road College Park, Maryland 20740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: if ite
any injury or oti 1 DBurial 2 □ Cremation 3 □ Removal from State Gate of Heaven Cemetery 8/29/2006 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, PA 4400 Powder Mĭll Road Beltsville, Maryland20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pancreatic Cancer **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if my cause, immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine physicien and s the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 24 No Year Month Dav 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension; Spinal Stenosis; Deep Venous Thrombosis; 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown should Pulmonary Embolism 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has birector, page 2 s performed? 1 ☐ Yes 2X No 1 Yes 2 No Medical Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 | Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No within 24 hours after death To the Funare! Director; , completely filled in by the f 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) August 25, 2006 D55559 HIB 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Thomas E. Maslen, M.D. 7525 Greenway Center Drive,#316 Greenbelt, Maryland 20770

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG

3 0 2006

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month 622 26 4a. Facility Name (If not institution, give street and number) 4c. Gounty of Death Jol. Wicomico er ver 1 Year | If Under 24 Hrs 5. Social Security Number Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1□M 20 F 258-32-9060 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Hartley Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 NNo If Yes, Give V Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 1 No Specify Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Suman Rober 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 daughter 20b. Place of Disposition (Name of cemetery, crematory or other p Yoromaka M 20a. Method of Disposition Date 20c. Location - City or Town, State or other place 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Macedonsa (-cm 21. Signature of Funeral Service Licenses 22. Name and Address of Facility , O. Box 33 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Coronar Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): regnancy 23d. Date of delivery 3 Ectopic pregnancy Month of death 5 Other (specify)

Pnysician /Medical Examiner

Physician

/Medical

Examiner

10a State

Funeral

Director

r than "naturel", or Items 23s or 28s-f show the Medical Examinar must be notified at

Ith and Mental Hygis 27 is marked other traumatic event, II

nt of Heelth a :: If Item 27 Is : or other train

Important: I any injury o once.

by Funeral Director

Completed

Be

with the Maryland

filed within 72 hours after death

Pages 1 and 2 should be

Baltimore, Maryland 21215-0036

Physician/Medical Examiner the attending physician and hed for use as the burial-transit detached for ģ Completed Be Certification: To

The law requires that the death certificate be executed

Box 68760.

P.O. I

Division of Vital Records,

	I .	
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 Ectopic pregnancy 5 Other (specify)

23e. Did tobacco use contribute to the cause of death? 1 🗆 Yes 2 No 3 Probably 4 TUnknown

24a. Was an autopsy performe 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

26. Place	of Death C	heck only one)	
Other: 4 🗆 Nur	sing Home	5 Residence	6 □Other (Specify
Injury at	28d	Describe how ini	ury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

26. Place

one)		and manner stated.
29b. Signature	and title of certifier	1
	F M	MI

5 Pending investigation

6 Could not be determined

25. Was case referred to medical examiner?

2 No

1 ☐ Yes

27. Manner of Death

2 ☐ Accident

3 ☐ Suicide

29a, Certifier

Medicai

4 - Homicide

1 Natural

29c. License number

28c. Injury at Work?

1 Tes

29d. Date signed (Month, Day, Year)

82606

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

1 / Inpatient

28a. Date of Injury (Month, Day Year)

Eas 31. Date filed (Month, Day, Year)

State Registrar

AUG 3 0 2006



2 ER/Outpatient 3 DOA

28b. Time of Injury

06-06458 Mallory Clair

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 29281

		1- For State Registrar		Certit	icate of	Death				F	eg No			,	
Physici dical Exami	an/	Decedent's Name (First, Midd Mallory							1	Date of Dea Month	ath Day	Year		Time of Death	7
CUICAI EXAIIII	Her	4a. Facility Name (if not instituted		umber)	4	b. City, Town	n, or Loc	cation of I		August 2		lc. County of	Death	10011110	-
		Memorial Hospital				Cumber						Allegany			
Funeral Director		5. Social Security Number 214-25-7136	6. S ex	7. Age (In yrs. last 17	birthday) Yrs.	If Under 1 Months	$\overline{}$	If Under 2 Hours	Min.	8. Date of Bi	,	1	Foreign	lace (State or try) Marylar	nd
δ.		Usual Residence of Decedent		10c. City, To	wa or Loosti								140	Od Inside City Limits	7
d Iow any		10a State 10b. County Maryland A	allegany		berla									X Yes 2 No	
arylane 8a-f sh at onc	Director	10e. Street and Number 10f. Zip Code								10g. Citizen of What Country?					
2 should be filed within 72 hours after death with the Maryland b and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at once.									U.S.A.						
ath wit Items 2	Funeral	11. Marital Status 1 X Never Married 2 M	larried Armed F			s Decedent of es, specify C					D-	White,	etc.	n Indian, Black,	
ofter de		3 Widowed 4 Div	1 Yes vorced If Yes, Give Ye or Dates:	2 X No	1	Yes 2X	No s	pecify:				Specify:	Whit	je.	
hours a matura Exami	ed by	15 Decedent's Education (Spe	ecify only highest gra	ade completed) 16	Sa. Decedent during mo	r's Usual Occ ost of working					16b.	Kind of Bus	iness/Ind	ustry	7
5-0036 Iled within 72 hours afte Hygiene I other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12)	College	1-4 01 5+)	stud	dent					5	stude	nt		
5-0036 iled within 7 Hygiene I other than		17. Father's Name (First, Middle		<u>_l</u> .			1			irst, Middle,		,			1
2121 ould be fill Mental I marked c event,	То Ве	John Clair,			19b. Mailing	Address (S				Benn	ett imber, City or Town, State, Zip Code)				+
ages I and 2 shount of Health and I is I friem 27 is rother traumatic	_	James Twigg	step-f	ather	640 \$	Shriv	er.	Avei	nue	, Cum	ber	cland	, MI	21502	
ore, es land of Heal If iten		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Park 09/01									20c. Location - City or Town, State Frostburg, Marylan				
Baltimore, permit Pages I ar Department of Hes Important: If ite		4 Donation 5 Other S 21. Signature of Fugeral Service		Fro	stbui	ame and Add	mor	ia L`	557	5	7 I	rost	A = = 6		
Ba perm Depa Impo		John R.	Durs	1	Dui	rst F	une	ral		ne	E	rost	burg	g, MD2153	32
Physician /Medical		23a Part I. Enter the disease, or failure. List only one cause		caused the death. De	o not enter th	ne mode of d	ing, suc	ch as car	diac or r	espiratory ar	rest, si	hock, or hea	rt	Approximate Interval Between Onset and	
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Box 687 e death certific the attending ed for use as t	Physicia	past 12 months? 4 Pregnant at time of death 5 Other (Specify) 9 Unknown													
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ital Recident The scertificate rector, page		25. Was case referred to medical	al I			26 F	Place of	Death (C	heck on	1 Yes	2	No 1	✓ Yes	2 No	4
Vita hysician this cer	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2 🗸 El	R/Outpatient		TO46	or =		Home 5	Resid	dence 6	Other		1
n of Jaing Ph	on: T	27. Manner of Death	A., (Mon	th Day Year)	8b. Time of Ir 209 hrs	njury 28c.		at Work?	IР	8d. Describe assenger					
Division tal or Attendir rs after death al Director: A led in by the fu	icati	2 Accident Inve	estigation 28e Pla	ice of Injury - At hom		et, factory, off				8f. Location	Street	and Numbe	r or Rural	Route Number, City	-
Divi	Certification:		uld not be ermined (Specify	Major Road /	Highway				R	or Town, t. 28 Wile	State) ytow	n, UNK, N	/ld.		
Division of Vital Records, P.O. Box 68760, within 24 hours after dening Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical (29a. Certifier (Check only one) Certifying F	aminer:On the basis	est of my knowledge, s of examination and	death occur or investigat	red at the tim ion, in my op	ne, date inion, de	and place	e, and d irred at t	ue to the cau	se(s) a and p	and manner a	as started ie to the c	: :ause(s)	
To T To Com	Med	29b. Signature and title of certifi	and manner	stated.			cense n					Date signe			\dashv
2		Caral,	HOLL	pu		C	.C.M.	E.			Au	igust 29,	2006		
2		30. Name and address of person Carol Allan, MD As		use of death (Item 23 I Examiner 1		Street Ba	ltimore	e MD 2	21201		•				1
nr.X	tate			Registrar's Signature	-			-, 2	201						\dashv
Regis		AUG 3 V	7000	A.	Base	1. 1									- 1

			1 State	State of Marylan		artment of H		d Mental Hy	giene	5 29282
			Registrar 1. Decedent's Name (First, Middle, Last)		001	inicate of t	Jean	2. Date of De	aath	3. Time of Death
	Physici /Medio		Lucille Delores	Carpenter				August	28, 2006	11:00 A M
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of D		4c. County of D	
			5. Social Security Number 6. Sec			Walde If Under 1 Year		Hrs. 8. Date of Bi	Charle	
	Funeral Director			M 2□XF 75	Yrs.	Months Days			ay, Year)	Birthplace (State or Foreign Country) ashington, DC
	pug *		Usual Residence of Decedent 10a. State 10b. County	10c City	, Town or Los	cation				
	Maryla 1 sho	ō	Maryland Charles	· · · · · · · · · · · · · · · · · · ·						10d. Inside City Limits 1 ☐ Yes 2√☐ No
	r 28a-	Funeral Directo	10e. Street and Number	W	aldorf	10f. Zip Code			10g. Citizen of What	Country?
	th with	alD	2005 St. Thomas Dr	rive, Apt. 101		20602			USA	
	tams	uner		12. Was Decedent Ever in U. Armed Forces?		Vas Decedent of Hi Yes, specify Cuba	spanic Origin' n, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
36	urs aftu	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates:	1	☐Yes 2⊠No	Specify:		Specify:	White
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28a-f show the Mudical Examinar musi be notified at	Completed	15. Decedent's Edu (Specify only highest grade	cation	16a. Deced	ent's Usual Occupa	ition		16b. Kind of Busine	ss/Industry
121	Mahin han	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	kind of work done of OO NOT use retired,)	Working	DO 0 .	D
Q 0	filed v Hygie other 1		10 17. Father's Name (First, Middle, Last)		Die	tician	18. Mother's	Name (First, Middle		Bd of Educat
<u>lan</u>	Aental rked rlc ev	To Be	John W. Kidwell					a E. Peap		
Maryland	2 sho and I is ma		19a. Informant's Name/Relationship (Ty)	·			nd Number o	r Rural Route Numb	er, City or Town, State	
e, P	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Mudical Examinat must be notified at once.		John G. Carpenter 20a. Method of Disposition		6143 E	Edsall Rd	Uni	t O, Alex	andria, VA	22304
Baltimore,	ages ant of nt: If It y or o		1 Surial 2	emoval from State	emetery, crem	thodist C				
altii	permit. F Departm Importar any injur		21. Sign the of Funeral Service License			Name and Addres			Camp Spri 1d Washing	
<u> </u>	89 5 8		Markells	ohaun		ntt Funer	al Hom	e POB 15	6, Waldorf	, MD 20604
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on						rrest,	Approximate Interval Between Onset and Death
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•	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consequ	ence of):	117				
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99 3	ing ph	Medi	IF FEMALE:							
Вох	that the death certific ad by the attending p detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal	death 3□l	Ectopic pregnancy			23d. Date of o	delivery Day Year
P.O.	t the de by the tached	yslo	1 ☐ Yes 2 ██¶o 9 ☐ Unknown	4☐ Pregnant at time of de 9☐ Unknown	atn 5⊔	Other (specify)				
S, D	The law requires that the death certificate be executed site has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by P	Part II. Other significant conditions con	tributing to death but not resul	Iting in the un	derlying cause give	n in Part I.	j		to the cause of death?
Division of Vital Records,	w require been si should t	ted	ODSI/MC	rive Skee	P A	youa		12	Yes 2□No 3□	Probably 4 Unknown
3ec	has b	Completed	17 Pain	ension)			24a. Was	osy prior t	autopsy findings available completion of cause of
Ta .	ysician: The is certificete hadirector, page		25. Was case referred to ledical	nosesterou	emic	X		1 ☐ Yes		
<u> </u>	ysicia lis cert direct	To Be	examiner?	ospital: 1 Inpatient 2 E	R/Outpatient	3□ DOA Othe		Death Check only o	nnel dence 6 □Other (Si	pacify)
0 0	ing Ph Kiter th		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work			now injury occurred	
isio	Attending or death. ector: After by the funer	Icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At hor	ne farm stro		es 2 No	29f Location /	Street and Number as	Don't Control
≧	after after I Dire	Certification;	4 Homicide determined	building, etc. (Specify)	ile, iaim, stre	et, ractory, office		City or To	Street and Number or vn, State)	Hurai Houte Number,
	Tospit 4 hours uners ety fille		29a. Certifier 1 Certifying Phys	ician: To the best of my knowner: On the basis of examination	riedge, death	occurred at the time	e, date and pla	ace, and due to the	cause(s) and manner	as stated.
	To the Hospital or Attending Physician: within 42 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director; to	Medical	one) 29b. Signature and Jitly of certifier	and manner stated.		29c. License			29d. Date signed (Mo	
	⊢≯⊢ŏ		Mha (Inais				280	08/29	106.
(2 12		30. Name and address of person who con	mpleted cause of death (Item	23a) (Type, P	rint)	- , , ,	.0	1 1 0 1	7 7 . / 2
न	x0 '(Abbas A. O.1 31. Date filed (Month, Day, Year)	nais, mo	70	Post 0	Frict	e Koad	-Waldorl	106. =, MD. 20602
SAL.	Sta Registra		AUG 3 0 2	32. Redistrar's Signatu		hack s				1

Physic /Med Exam

within 24 hours after death. To the Funeral Director: After this certificate hes been signed by the attending physicien and gompletely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed

	1 - State Registrar	/Fi		(Certifica		Death	2. Date of Dea	jiene leg. No.		2 T 12	
ın		e (First, Middle, Last)						Month Month	Day	Year	3. Time of Death	
al		Le A. Coyn			4h Cin	Tour	al anning of Document	Itug vs!	28	county of Death	03.30	
er	4a. Facility Name (//	f not institution, give :	street and number)	16-1	4b. City	y, 10wn, 0	Location of Death	1	46. 0	C'		
	5. Social Security N		A NIEDICI	B (In yrs. last birth	nday) If Unde	er 1 Year	If Under 24 Hrs.	8. Date of Birt		9. Birth	place (State or Fore	
	189-28-0	1	M 2 A F		rs. Months	Days	Hours Min.	Sept. 2	, Year)	Cor	^{intry)} nsylvania	
	Usual Residence of	Decedent						1= -F				
_	10a. State	10b. County		10c. City, Town							10d. Inside City Lim	
Director	DE	Sussex		Delma						1 ☐ Yes 2 🛣		
	10e. Street and Nur		<i>a</i> 1 1 D		10f. Z	ip Code			-	on of What Cou	intry?	
ra		rovidence			10 Mas Das	1994		accifu Vac or No		4. Race - Amer	ican Indian	
Funeral	11. Marital Status		12. Was Decedent Armed Forces? 1 Yes 283		If Yes, sp	edent of F	lispanic Origin? (S an, Mexican, Puert	o Rican, etc.)	''	Black, White		
by F	3 Widowed	ied 2 X Married 4 □ Divorced	If Yes, Give Year or Dates:	10	1 🗆 Yes	2 🕱 No	Specify:		5	Specify:	White	
		15. Decedent's Edu		16a. I	Decedent's Us	ual Occup	ation		16b. Kind	d of Business/I	ndustry	
Completed	(Spec	ify only highest grad	e completed) College (1-4or 5		(Give kind of w life. DO NOT	vork done use retire	during most of world)	rking				
E		11	College (1-40) S	,+,	Но	mema]	ker			Home		
0	17. Father's Name	(First, Middle, Last)					18. Mother's Nar	ne (First, Middle,	Maiden S	iumame)		
To B	William	Swain					Elva I	lotcher?				
	19a. Informant's Na	ame/Relationship (Ty	rpe, Print)	19b.	Mailing Addre	ss (Street	and Number or Ru	ıral Route Numbe	r, City or	Town, State, Z.	ip Code)	
	Thomas 1	R. Coyne,	Sr. (Hust	and) 38	3021 Pr	ovid	ence Chui	ch Rd.	Delm	ar, DE	19940	
	20a. Method of Dis		Anna Chair	20b. Place of cemetery	Disposition (N v, crematory or		ce)	Date	20c. Loca	ation - City or 1	Town, State	
	1 Burial 2 Excremation 3 Removal from State 4 Donation 5 Other (Specify) Crematory of Delmarva Aug. 29, 2006 Delmar, Delaware											
	21. Signature of Fu	ineral Service Licens	ee	11	22. Name	and Addre	ss of Facility eral Home					
	Unu	+ Ohe	nt Deu	sell		_	rove Stre		lmar,	DE 19	9940	
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death		
Examiner												
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358 es Corraro		State of Maryland / Dep	artment			е			
		Registrar	rtificate	of Death		Reg. No.	201	3. Time of Death	
Physicia cal Examir	ner	1. Decedent's Name (First, Middle,Last) Frances Anne Corra	ro		Mon Aug	ust 25, 2006		0756 hrs	
pris 6		4a. Facility Name (if not institution, give street and number) Penninsula Regional Medical Center		4b. City, Town, or Location Salisbury		V	County of Deat		
Funeral Director		5. Social Security Number 6. Sex 1 Age (In yrs. 76 1 M 2 ★ 76			tina Alia	/08/193	Forei	rthplace (State or gn puntry onnecticu	
laryland 8a-f show any at once.	Director	Maryland Howard E	y, Town or Loo Cllicot	t City 10f. Zip Code		10g. Citiz	zen of What Cou	10d. Inside City Limits 1 X Yes 2 No untry?	
DEMINITIONE, IND Z 1 Z 1 3-0030 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland permit. Pages I and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		4800 Dorsey Hall Drive 11. Marital Status 1 Never Married 2 Married Armed Forces?		21842 Was Decedent of Hispanic C If Yes, specify Cuban, Mexic		es or No-	ISA 14. Race - Amer White, etc.	rican Indian, Black,	
urs after de tural", or i	by Funeral	3 X Widowed 4 Divorced of Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	1 16a. Decer	Yes 2½ No specident's Usual Occupation (Given			Specify: W	nite /Industry	
thin 72 houre. than "natedical Exa	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	g most of working life. DO NO emaker		mestic	,			
Definition, will Z 12 13-000 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical	Be Con	17. Father's Name (First, Middle, Last) Pasquale J. Parillo	Surname)						
2 should the and Mer 27 is mar umatic even	To	19a. Informant's Name/Relationship (Type, Print) Evelyn Parillo/sister		nber, City or Town, State, Zip Code) 1, DE 19973					
Pages 1 and ent of Healt nt: If item		20a. Method of Disposition 1		20c. Location - City or Town, State Hamden, CT					
permit. P Departme Importa injury or		21. Signature of Funeral Service Licensee CFS P		Cemetery Name and Address of Fac HOIIOWay Fun 501 Snow Hil	neral Home	e Profe alisbur	ssional	Association 1804	
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the deat failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence	clerotic Ca			atory arrest, sho	ck, or heart	Approximate Interval Between Onset and Death	
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):							
e executed sian and ial - transit	- 1	d d AMENDED				-			
The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transi	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 ✓ No 9 Unknown 23c. If yes, outcome of pre	2	Fetal death 3 Ecto Other (Specify)	opic pregnancy	230	d. Date of deliver Month	ry Day Year	
ires that the death certifi signed by the attending I be detached for use as	ā	Part II. Other significant conditions contributing to death but not Right femur fracture, dementia	n Part I. 23	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✔ Unknown					
cian: The law require certificate has been si ector, page 2 should b	Completed					a. Was an autopsy performed? Yes 2 N	prior to death?	utopsy findings available completion of cause of	
in: Th		25. Was case referred to medical		26.Place of Dea	ath (Check only one			65 2 110	
hysicis this ce I direc	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	ER/Outpation	ent 3 DOA Other4	Nursing Home	5 Reside	nce 6 Othe	er:	
tending Physician: leath. tor: After this certifi the funeral director,	ation: T	27. Manner of Death 1 Natural 5 Pending 2 ✓ Accident Investigation 28a. Date of Injury Juli 30, 2006 28a. Date of Injury Juli 30, 2006	28b. Time (1 Yes 2	Subje	escribe how inju ct fel!	iry occurred		
To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should law to the funeral director, page 2 should be a standard or the funeral director.	Certification:	3 Suicide 6 Could not be determined (Specify) Nursing H		treet, factory, office building.	or	Town, State)		ural Route Number, City 6, Ellicott City , MD	
To the Hos within 24 har To the Fun completely	Medical (29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowle and manner stated.		igation, in my opinion, death	occurred at the tim	ne, date and pla	ce, and due to t	he cause(s)	
	ž	29b. Signature and title of certifier A P D C HOLDAN		29c. License numb O.C.M.E.	per		Date signed (Mountains) ust 26, 2006		
		30. Name and address of person who completed cause of death (Ite Carol Allan, MD Assistant Medical Examiner		n Street, Baltimore, N	MD 21201				

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

Carol Allan, MD Assistant Medical Examiner 32. Registrar's Signature

31. Date filed (Month Day Year) Q 2006

ORIGINAL

		•	- For Amend #20b Per FH G859 9/20/06	artment of Health and Menta Intrinsite of Death	Reg. No.				
	Physicia	an	Decedent's Name (First, Middle, Last) Solomon Cohen	Moi					
	/Medio		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	gust 28, 2006 1:39 [™] 4c. County of Death				
			503 Elberta Ave. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Salisbury If Under 1 Year If Under 24 Hrs. 8, Date	Wicomico				
	Funeral Director		442−18−0037 1.2 M 2□ F 87 Yrs.	Months Days Hours Min. (Mo	e of Birth nth, Day, Year) 9. Birthplace (State or Foreign Country) New York				
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits				
	a-f she	ctor	Maryland Wicomico Salish	oury	1 □ Yes 2 X No				
	h with the 23a or 28 st be no	al Director	10e. Street and Number 503 Elberta Ave.	10f. Zip Code 21801	10g. Citizen of What Country? USA				
036	J within 72 hours after death with the Maryland iden. Jen. Then. The "natural", or items 23a or 28a-f show the Medical Examination and the Med	by Funeral	11. Marital Status 1 Never Married 2 A Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Yes 2 No Yes Army Year or Dates: AIR CORP	Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican, of 1 ☐ Yes 2 🛂 No Specify:	s or No- etc.) 14. Race - American Indian, Black, White, etc. Specify: White				
2-0	72 ho	leted	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of working	16b. Kind of Business/Industry				
21215-0036	within pene. r then	Completed	Flomentary/Secondary (0.12) College (1.40r.5+)	oir & Maintenance	Aviation				
land ;	be filed tal Hyg d othe event,	To Be C	17. Father's Name (First, Middle, Last) Wolfe Cohen		Middle, Maiden Sumame) senberg				
Maryland	nd 2 should be f lith and Mental h 27 Is marked of r treumatic eve	-		ling Address (Street and Number or Rural Route 03 Elberta Ave., Salis					
Baltimore,	Pages 1 and 2 nent of Health a int: If Item 27 Is iry or other tree	ĺ	1 N Burial 2 □ Cremation 3 □ Removal from State	sposition (Name of remaiory or other place) Beth-El 9/03/2006 9/03/2006 San Antonio, TX					
Balti	permit. Pages 1 Department of H Importent: If Ite any injury or ot once.		21. Signature of Funeral Service License e	Horloway Funeral Home 501 Snow Hill Rd., Sa	Professional Association lisbury, MD 21804				
	Physician /Medical Examiner transit the pring-transit transit the principle of the	al Examiner	23a. Pant1. Enter the disease, or complications that caused the death. Do not enshock, or heart faiture. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Little Charlet C	tory Fasufficiency on Multiple Medical Co GI Bleeding, Anemi	6 No.				
.O. Box 687	the death certifi by the attending ached for use as	Physician/Medical		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year				
S, P	res thal igned to be det	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23	e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown				
Records,	The law requir	Completed	Coverary Hotely Viscose		a. Was an autopsy performed? Yes 22 No				
Vital R		BeC	25. Was case referred to medical examiner?	26. Place of Death (Chec	7				
of	d is	1: To	1 Tos 25 No Hospital: 1 Inpatient 2 EP/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time		X Residence 6 ☐ Other (Specify) scribe how injury occurred				
ion	Attending redeath. actor: After by the funer	atlor	1 Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No					
Division	l or Atter after de Diracte	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office 28f. Loc City	cation (Street and Number or Rural Route Number, y or Town, State)				
	To the Hospitel or Attending Phywithin 24 hours after death. To the Funerel Director: After the Completely filled in by the funeral	edical C	29a. Certifier (Check only one) 15 Certifying Physician: To the best of my knowledge, dea 2 Medical Exeminer: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occurred at th	e time, date and place, and due to the cause(s)				
)	To th withir	Me	29b. Signature and title of certifier	29c. License number 024986 9. Print) - B101 Salisburg Md. 2	29d. Date signed (Month, Day, Year)				
(901X		30. Name and address of person who sampleted cause of death (Item 23a) (Type Abbert V. Reilly ma 560 hoverside Pr	. Print) . Blo/ Salisbury Md. 2	180,				
	Sta Registi		31. Date filed (Month, Day, Year) 32. Ragistrar's Signature	bodi					

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** РМ Barbara Joyce Callahan September 6, 2006 2:25 /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9395 Peter Roy Court Frederick Frederick If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year Months Days 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🛛 F 59 July 29, 1947 Pennsylvania Director 197-38-4549 Usual Residence of Decedent 10c. City. Town or Location 10a State 10b County 10d. Inside City Limits Worle ret', or iteme 23s or 28s-f ehov Examiner must be nutified at 1 X Yes 2 ☐ No Director Virginia Fairfax Burke 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9395 Peter Roy Court 22015-4250 Completed by Funeral USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 K No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mertel Hydiene.
Interference of the Transked other than "natural; or liter uny or other transmit, it is Madical Earthne.
Into or other transmit is event, Its Madical Earthne. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 M Divorced White 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 5+ high school mathmatics teacher public school 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Anthony Ambrose Marva Catherine Louise Hanzely 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa Marva, sister 434 Bunny Lane, Harpers Ferry, West Virginia 25425 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 19/9/2006 Smithsburg, Maryland 21. Sonature Funeral Service Licensee 22. Name and Address of Facility Keeney and Basford Funeral Home M00999 106 East Church Street, Frederick, MD 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or releast failure. List only one cause on each line. Approximate Interval Belween Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Cerebrovascular Accident /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner attending physicien and for use es the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{No} \) Day Year 4 Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Vulvar Cancer 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed 1☐ Yes 2X No 1 Yes Division of Vital Hospitei or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Sister s ٩ 1 ☐ Yes 2 X No this After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Residence 1 XNatural 2 ☐ Accident 5 Pending investigation efter death.

Director: Aft
d in by the fur 1 Yes 2 No 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 | Homicide within 24 hours e To the Funeral I 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0062011 September 11, 2006 30. Name and address of person wire completed cause of death (tem 23a) (Type, Print) Ginger Gardner, MD, Johns Hopkins Hospital, 600 North Wolfe St., Baltimore, MD
31. Date filed (Month, Day, Year) 32. Registrar's Signature 21287

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Registrar

31. Date filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene 2006 29287 Certificate of Death 1. Decedent's Name (First, Middle | Last) 2. Date of Death 3. Time of Death Month **Physician** 5 September 1215 P M Shirley Ruth Caldwell 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** SunBridge Care Center E1kton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, April 18, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🛛 F Director 265-70-3305 64 Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Itams 23a or 28a-f show the Medical Examinar must be notified at 1 XYes 2 No Directo Cecil Maryland E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 451 North Street 21921 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: δ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should ba filed within 72 I Department of Health and Mental Hygiene Importent: If Item 27 is marked othar than "natt any injury or other traumatic aven?" Automobile Elementary/Secondary (0-12) College (1-4or 5+) Assembler Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Fred Thomas Greer Vestie Nichols 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Maxine Campbell/Sister P.O. Box 30, Rising Sun, Maryland 21911 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State September 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State `4 □Donation 5 XOther (Specify) Entombrent Gracelawn Memorial Park 8, 2006 New Castle, Delaware 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, Maryland 21921 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) With metastasis **Physician** UNG Cancer /Medical Due to for as a/co Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760 attending physician 8 Physician/Medical as the esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy be detached for in the past 12 months?
1 Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 24a. Was an autopsy 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 2 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) completely filled in by the funeral 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Director: After Ratural 5 Pending investigation 1 🗌 Yes 2 🗌 No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated To the P within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6/06 0063720 Ut 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ste 3B Elkton Street 178 NOOTE 31. Date filed (Month, Day, Year) 2006 Registrar

Please Type or Print in Black Indelible Ink

iaid Allen Da		State of Maryland / Departmen 1- For State Registrar Certificate			and	Menta			Reg. No	20		2928
Physici dical Exam		1. Decedent's Name (First, Middle,Last) Ronald Allen Davis						Date of Do Month May 27,	Day 2006	Year		Time of Death 2100 hrs
>		4a. Facility Name (if not institution, give street and number) 445 Bond Street	4	b. City, Tov Cumbe		ocation of D	Death			c. County of I	Death	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 11 M 2 F 50	y) Yrs.	If Under	1 Year Days	If Under 2 Hours	4Hrs. Min.	8. Date of I	•	16	oreian	ry) Maryland
nd show any ice.	7.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Allegany Cumberland								- 1	od. Inside City Limits	
ith the Maryland 23a or 28a-f show	Director	10e, Street and Number		10f. Zip Co				Ī		tizen of What	Country	?
fter death w "", or items er must be	by Funeral [Armed Forces? Never Married Armed Forces?	If Ye	Decedent s, specify (of Hispa Cuban, M	Mexican, Pu			U.S.	14. Race - / White, e		n Indian, Black,
5-0036 led within 72 hours at Hygiene other than "natural the Medical Examin	ompleted t	 Decedent's Education (Specify only highest grade completed) 16a. Decedent 	ng mo	s Usual Oc st of workin						Kind of Busin		
ID 21215-0036 should be filed within 7 and Mental Hygiene 7 is marked other than natic event, the Medica	To Be Cor	17. Father's Name (First, Middle, Last) Lloyd F. Davis, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. M.	Address (Ma	ary Vir	(NUNE) Hame (First, Middle, Maiden Surname) rginia Clise r or Rural Route Number, City or Town, State, Zip Code)						
e, MD. I and 2 shou Health and I item 27 is not traumatic	_	John M. Davis / Son 818	Aver	nue, Cu	mber	land,	MD 21	.502				
Baftimore, MI permit. Pages 1 and 2 s Department of Health as Important: If item 27 injury or other traums		20a. Method of Disposition 1	or othe	er place)		·		/2006	-	Location - Ci		vn, State
Baitimore permit. Pages 1 Department of F Important: If injury or other			22. Na	ame and Ad hurch Creen	dress o	f Facility	——— р. Р	Α.			, rid	
Physician /Medical Examiner	Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Approximate Inter Between Onset a Death Due to (or as a consequence of): b										
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal - transi	edical	d UNPENDED IX AMENDED item#21.perFH.C 23c. If yes, outcome of pregnancy		.9/14/0	06 T	[23	d. Date of de	livery	
e death certificate be the attending physici ed for use as the buri	Physician/M	23b. Was decedent pregnant in the past 12 months? 1	1	al death er (Specify		Ectopic pre	egnancy	1		Month	Day	Year
ires that the signed by l be detach	ð	Part II. Other significant conditions contributing to death but not resulting in t	the un	derlying ca	use give	en in Part I.		I	_			cause of death? y 4 Unknown
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tal or Attending P rs after death. al Director: After	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 O with 6 Could get be 1.00 Page 1.00 P								Route Number Cit		
To the Hospital or within 24 hours aft To the Funeral Di completely filled in		3 Suicide 4 Homicide Could not be determined (Specify) Single Family 29a Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or inves	ccurre	ed at the tim	ne, date	and place,	44 and du	or Town, 5 Bond S	State) Street, use(s) ar	Cumberla	and, M started.	D
To th withi To th	Medical	29b Signature and title of certifier	uyauc	29c. Li	icense r	number	eu at th	e ume, gat	29d.	Date signed y 28, 2006	(Month,	
		30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 11	1 Pe	nn Stree	t, Balt	imore, N	1D 21:	201	1			
S	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature		Art S		<u> </u>						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 29289 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2006 AUGUST 27, **Physician** FRANK **EPHRAIM** 4:00PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4906 ESSEX AVE CHEVY CHASE MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) FEBRUARY 19,1931 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Days Hours 10XM 2□F Yrs. GERMANY 75 546-40-7204 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location * one 10a. State 10b. County 10d. Inside City Limits r than "natural", or iteme 23a or 28e-f ehov the Medical Examinar must be notified at 1 XYes 2 No MARYLAND MONTGOMERY CHEVY CHASE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4906 ESSEX AVE 20815 UNITED STATES OF AMERICA deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: KOREA 1 Never Married 2 X Married 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ENGINEER UNITED STATES GOVERNMENT permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If item 27 is marked other the enty injury or other traumatic event, Las once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CHARLOTTE HEYMAN CURT EPHRAIM ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CHEVY CHASE, MD 20815 RUTH EPHRAIM - WIFE 4906 ESSEX AVE. 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State JUDEAN MEMORIAL GARDEN 08/29/06 OLNEY, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityHINES RINALDI FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 11800 NEW HAMPSHIRE AVE, SILVER SPRING, MD 20904 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 3 MONTHS METASTATIC BRAIN CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a sollsequence of). ending physiclen and use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2□ No certificate 1 Yes 2 No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐XNo ٩ After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death, 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

or Attending Physician: The law requires that the death certificate be executed of Vital Records, P.O. Box 68760 Division ours efter death, neral Director: A filled in by the fu To the Hospitel within 24 hours e

Baltimore, Maryland 21215-0036

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of confiler 29c. License number D003-3293 AUGUST 28, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5454 WISCONSIN AVE SUITE 1300, CHEVY CHASE MD, FRED SMITH, MD

State Registrar

Medicai

31. Date filed (Month, Day, Year)

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			1 - For State Registrar	State of Mar	yland / Depa <i>Cei</i>	artment of Heal tificate of Dea	th and Mental H	ygiene Reg. No.	006	29290
	Physici /Medic		Decedent's Name (First, Middle, Last) Ber	nice:	J. E	lam	2. Date of Month	Death Day 28	Year 2006	3. Time of Death 95 30 A M
	Examir		4a. Facility Name (If not institution, give s Sunpise A56) 5. Social Security Number 6. Sex	ted Livi	(In yrs. last birthday)	4b. City, Town, or Loca Columb If Under 1 Year If U	Inder 24 Hrs 9 Date of F	F F	ounty of Death	
	Director			M 2⊠F 8	6 Yrs.	Months Days Ho	ours Min. (Month.) July	20, 19		olace (State or Foreign only) ington, DC
	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any Injuryae other traumatic event, the Madical Examiner must be notified at once.	rai Director	Maryland Howard 10e. Street and Number 6500 Freetown Road		Columbia	10f. Zip Code 21044		Unit	n of Whal Cour	es
9600-	hours after de itural', or items al Examiner n	Completed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Midowed 4 Divorced	2. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		f Yes, specify Cuban, Me	ic Origin? (Specify Yes or I exican, Puerto Rican, etc.) ecify:	Sį	Black, White, pecify: B1	etc. ack
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Maryland	2 should be to and Mental I is marked or raumatic eve	To Be	William Jeter 19a Informant's Name/Relationship (Type			ng Address (Street and N	Marie Elliot Jumber or Rural Route Num	t nber, City or T	own, State, Zip	•
Baltimore, N	Pages 1 end ent of Health nt: If item 27		Josiah Epps Jeter 20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	(brother	20b. Place of Dispo cemetery, crer		ive, Clinton Date 9/1/06	20c. Loca	20735-2 Ition - City or To	own, State
Balti	permit. P Departm Importer any Inju		21. Signature of Funeral Service License	Clift	u 7	. Name and Address of 1	FacilityMcGuire F	uneral Wash. I	Servic	e 0012
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or complications, shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):		nonary dise		oPD)	Approximate interval Between Onset and Death
,0928	that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit	dical Examiner	fi any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):			_		
O. Box 6	the death certific y the attending p ched for use as f	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of 1□Live birth 2 4□Pregnant al li 9□ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	NIA	230	d. Date of delive Month	ery Day Year
۵.	w requires that the de been signed by the s should be detached		Part II. Other significant conditions con Chronic Pena	tributing to death bul	not resulting in the u	nderlying cause given in		Yes 2		he cause of death?
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Division of Vital	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	tlon: To Be	examiner?	ospital: 1 ☐ Inpatient 28a. Dale of Injury (Month, Day)		I 3□ DOA Other: 4			Other (Specif	A3513te
Divisi	sital or Attenurs after deat	Certification:	3 Suicide 6 Could not be 4 Homicide determined	building, etc.		eet, factory, office	28f. Location City or 1	Town, State)		al Route Number,
	To the Hosp within 24 hor To the Fune completely fi	Medical	29a. Certifier (Check only one) 2 Medical Examination one)	er: On the best of er: On the basis of e and manner state	xamination and/or in	occurred at the time, day vestigation, in my opinion 29c. License num	ate and place, and due to the time, death occurred at the time	e, date and pl	nd manner as s lace, and due to signed (Month,	the cause(s)
	5		30. Name and address of person who co	mpleted cause of dea	McD.	D 50	6531 Columbia,	Aug	28,	2006
	Sta		Harry U, 10 31. Date filed (Month, Day, Year)	780 Hick	's Signature	dge Rd,	Columbia,	m	710	74

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2006 2. Date of Death Decedent's Name (First, Middle, Last) September 7, 2006 Physician 4:12 A CLINTON W. **EVANS** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Crisfield Somerset 209 N. Somerset Avenue Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. Months Hours 1 XM 2 ☐ F 82 218-16-8047 Director December 16, 1923 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a State 10h County item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, it s Mayles! Example 1 at 1 XYes 2 No Crisfield Somerset Maryland Director 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 209 N. Somerset Avenue 21817 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after on the death and Mental Hygiene. Int: If item 27 is marked other than "natural", or Iter 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: À Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Confectionary Owner 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Estelle Corbin Gordon C. Evans 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rebecca Evans (Wife) 209 N. Somerset Avenue - Crisfield, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 6 permit. Page Department of Important: If any injury or once. Sunnyridge Memorial Park 9/10/06 Crisfield, MD 22. Name and Address of Facility Bradshaw & Sons Funeral Home 21. Signature of Funeral Service Licenses over 306 W. Main St. - Crisfield, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Beath Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence Examiner shews Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner attending physicism and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy
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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical npletely To the h within 2 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 29c. License number an wy D 16725 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) T 2 COUSTAN 1340 Wisivic Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2006 DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Reg. No.2 0 0 6 Certificate of Death 2. Date of Death Month I. Decedent's Name (First, Middle, Last) Day Physician Year August 25, 2006 3:25PM M Glodine Grangier /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 32698 Sea Tick Road Eden 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours Months Director 84 06-16-1922 West Virginia 236-24-7133 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23e or 28a-1 show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7.1s marked other than "natural", or Items 23e or 28e-f show treumatic event, the Medical Eventher must be rediffed at 1 ☐ Yes 2 No Director Eden Somerset 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 32698 Sea Tick Road 21822 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. Completed by 3 Widowed 4 ☐ Divorced Year or Dates: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker None Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Ira Webster Grace Lee Harrah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Webb/Daughter 3805 Powellville Road, Pittsville, MD 21850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 permit. Page Department c Important: If any injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory Salisbury, Maryland 08/29/2006 Signature of Funeral Service Licensee 22 Name and Address of Facility
Hinman Funeral Home 25a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. M00295 Princess Anne, MD 21853 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lung Physician aneer /Medical Due to (or as a consequence of): **Examiner** TN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? this certificate 1 ☐ Yes or Attending Physician: 25. Was case reterred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient Certification: To 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Injury To the Hospitel or Attendii within 24 hours after death. To the Funerel Director: At 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 Homicide 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and Ittle of certifier 29d. Date signed (Month, Day, Year) 57952 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 106 Milford ST \$ 405B Solisbury Babulal 32. Regisfar's Signature 31. Date filed (Month, Day, Year) State AUG 2 9 2006 Registrar

Please Type or Print in Black Indelible Ink

Mary Louise Harrington State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Rea. No Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mary Louise Harrington Month August 27, 2006 Month 1240 hrs Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 9700 Cedar Lane Bethesda Montgomery If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Months Davs Hours Director Countrinassachusetts 020-22-8750 78 June 22, 1 M 2 X F 1928 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location Ę 10a. State 10b. County 1 Yes 2 X No 28a-f show Maryland Montgomery Bethesda Pages 1 and 2 should be filed within 72 hours after death with the Maryland neut of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-5 sho Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country 9700 Cedar Lane 20814 USA Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc Never Married 2 2 **x** No Yes 3 XXWidowed 1 Yes 2 X No specify: Specify White Divorced Yes, Give Year 2 or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 the Medica 4 Teacher Education 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Henry J. Shea Margaret F. McDonnell Be 19a. Informant's Name/Relationship (Type, Print) ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) rtment of Health and M rtant; If item 27 is m y or other traumatic Kathryn Harrington-Hughes/Daughter 7588 Easton Club Drive, Easton, Maryalnd 2160 Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 x Burial 2 Cremation 3 Removal from State September Department of Gate of Heaven Cemetery Donation 5 Other Specify 2006 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line. Between Onset and /Medica Death a Smoke Inhalation complicated by Arteriosclerotic Cardiovascular Disease Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and UNPENDED AMENDED The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, IE EEMALE phy the k 23c If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Metastatic Renal Carcinoma Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has l performed? death? ✓ Yes 2 No After this certificate 1 🗸 Yes 25 Was case referred to medical 26.Place of Death (Check only one) To the Hospital or Attending Physician: Be Other₄ Hospital: 1 Inpatient ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other Scene 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) FOUND: 27. Manner of Death 28d Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Certification: Victim of housefire **FOUND** Natural 1 Yes 2 V No 5 Pending Director: the Aug 27, 2006 1236 hrs 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) determined (Specify) Single Family Home 9700 Cedar Lane, Bethesda, MD Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical within 2 To the 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c License numbe 29d Date signed (Month, Day, Year) ure and title 20 O.C.M.E August 28, 2006 ne and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Laron Locke MD. 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Pay, Ye. AUG 3 32 Registrar's Signatur State O 2006

Registra

PROBLET!

			1 - State Registrer	aryland /	Department of F Certificate of			giene Reg. No. 20 (
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Ellis Reid	Неа	ath		2. Date of Dea Month August	Day Ye	3. Time of Death
-	Examin Funeral Director	ier	4a. Facility Name (If not institution, give street and number) 409 Brookridge Dr., Apt. F. 5. Social Security Number 6. Sex 7. Agr $217-36-1575$	I e (In yrs. last 66	Salis	sbury If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Dat 9/2/1	4c. County of E Wicom.	
	ס	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Wicomico	10c. City, To	own or Location				10d. Inside City Limits 1½∏ Yes 2 ☐ No
	hours after death with the Maryland turel', or Items 23a or 28a-f show al Erar it artified to invilled all	Funeral	10e. Street and Number 409 Brookridge Dr., Apt. F 11. Marital Status 1 □ Never Married 2□ Married 11. Ves 2 ☑ Married	Ever in U.S.	10f. Zip Code 2180 13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto		10g. Citizen of Wha USA 14. Race - A Black, V	t Country? American Indian, Vhite, etc.
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Maryland 2	uld be filed Aental Hygi rked other tic event, I	To Be Co	17. Father's Name (First, Middle, Last) Clarence Lee Heath			18. Mother's Name Mary Po		Maiden Sumame)	
Σ	ss 1 and 2 should of Health and Men item 27 is marke other treumatic		19a Informant's Name/Relationship (Type, Print) Lois A. Heath/wife		9b. Mailing Address (Street 409 Brookric	dge Dr.,	Apt.H,		
altimore,	Page nent o ant: tf		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	ceme	e of Disposition (Name of etery, crematory or other place Lsbury Cremato	ce)	9/06	20c. Location - City Salisbur	
Ball	permit. Pag Department Importent: t any injury o		21. Signature of Funeral Service Licensee	SP	501 Snow	Hill Rd.	, Salish	oury, MD 2	
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lind line disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or ripiny that initiated events resulting in death) Last Due to (or as cause. Enter Undertying Cause (Disease or ripiny that initiated events resulting in death) Last Due to (or as cause. Enter Undertying Cause (Disease or ripiny that initiated events resulting in death) Last	a consequence	Chraic Obstructooth:				Approximate Interval Between Onset and Death
P.O. Box 68760	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	2 Fetal dea	ath 3 Ectopic pregnancy	,		23d. Date of Month	delivery Day Year
rds, P.	quires that n signed by	by	Part II. Other significent conditions contributing to death b	ut not resultin	g in the underlying cause giv	en in Part I.	23e. Did to		te to the cause of death? Probably 4 □Unknown
al Recol	iicien: The law requir certificate has been si rector, page 2 should I	e Completed	25. Was case referred to medical			Of Plans of Park	1 ☐ Yes	rmed? prior 2 No 1 □	e autopsy findings available to completion of cause of h? Yes 2 \(\sumbole\) No
Division of Vital Records,	tending Physeath.	Certification: To B	examiner? 1 Yes 2 No Hospital: 1 Inpatie 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident investigation 2 Spikids 6 Could not be	ry Year) 28t	Outpatient 3 DOA Oth b. Time of Injury M 28c. Injur M 1 1 , farm, street, factory, office	y at k? Yes 2 \Boxed No	me 5 Resid 28d. Describe h	lence 6 Other (sow injury occurred	Specify) r Rural Route Number,
۵	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	edical Ce	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one)	f examination	dge, death occurred at the tir and/or investigation, in my o	me, date and place, opinion, death occur	and due to the or	cause(s) and manne date and place, and	r as stated. due to the cause(s)
)	To the within To the comple	Me	29b. Signature and title of certifier Physician		29c. Licens	7291		29d. Date signed (M	onth, Day, Year)
	Sta	ate	30. Name and address of person who completed cause of d. T.C. Poetrowicz, p.o., 1820 31. Date filed (Month, Day, Year) 32. Registry	Sweet 6	Bay Drive, Si	ite 101,	Solishun	y, mp 2	1804
DH	Regist	5. H' .	AUG 3 0 2006 See	w B	Morde				
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any County		1 - For State Registrar 1. Decedent's Name (First, Min		of Maryland / De	partment of H ertificate of I		Reg	3. No.	3. Time of D
Physic /Medi		Helen E. James					Augus	t 25, 2006 Pear	13:20
Exami	- 7	4a. Facility Name (If not institu Frostburg Village		e Center	I	r Location of Death Frostburg		4c. County of Dea	
Funeral Director		5. Տջգիվ Տ գ ղանեն 195ber -21 7-10-6393 -	6. Sex 1 □ M 2 🕱 F	7. Age (In yrs. last birthda 87 Yrs	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1 18-Jan-19)	9. Bi 19 Ma i	rthplace (State or Country) yland
aryland show	2	Usual Residence of Decedent 10a. State 10b. Cou		10c. City, Town or Frostburg	Location				10d. fnside City
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bad la d	To Be C	17. Father's Name (First, Midd August Eichhorn				18. Mother's Name Martha Dot	, ,	aiden Sumame)	
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s 1 an if Heal item 2 other		20a. Method of Disposition		20b. Plac	Read SW		ate 2	Oc. Location - City of	r Town, State
	-	1 Burial 2 □ Cremation 4 □ Donation 5 □ Othe		State Frostburg	rematory or other place Memorial Park	29-A	ug-2006 Fro	stburg M	aryland
Permit Page Department o Emportment o Emportment: if my injury or		23a. P. Enter the disease or condition resulting in death)	or complications that List only one cause on	caused the death. Do not each line. Closed lugs of (or as a consequence of):	enter the mode of dyin	Home, 57 Fr		st,	Approximate Interval Betwoen and E
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The law requires that the death certificate be executed ate has been signed by the ettending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 Live	gnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	у	- Aca	23d. Date of d Month	elivery Day
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law requir les been si 2 should l	Completed by	mth inab	ility to	take Nutr	ition		24a. Was an autopsy	prior to	autopsy findings a
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Physician: Th r this certificate ral director, pag	To Be	25. Was case referred to med examiner?			itient 3 DOA Oth	4 Nursing Ho	me 5□Resider	nce 6 Other (Sp	pecify)
ol or Attending Ph after death. I Director: After thi d in by the funeral	ertification;	27. Manner of Death 1 Natural 5 Pe 2 Accident inv	nding 28a. Dat (Mo estigation Aug	e of Injury 28b. Tim 25 200 6 1:	ry Wo	ry at rk?] Yes No	28d Describe how patier	nt fell	
3 8 8 5 E	5		uld not be 28e. Placermined	ce of fnjury - At home, farm lding, etc. (Specify)	Stroot factory office		28fal ocation /Sth	urg MD	Bural Boute Num

To the Hospitel or Att within 24 hours after of To the Funeral Direct completely filled in by it

29b. Signature and title of certifier 6

State Registrar 29a. Certifier

7/1

31. Date filed (Month, Day, Year)

30. Name and address of person o completed cause of death (Item 23a) (Type, Print) S. L. S. h.r. M. Tarn Te M.O. 48 Tarn Terrace, Fro thury Maryland 21532 32 Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

14464

29d. Date signed (Month, Day, Year)

8/26/2006

State of Maryland / Department of Health and Mental Hygiene 29296 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** George Washington King, Jr. August 28 2006 9:10 P^{M} /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 8787 Endless Ocean Way Columbia Howard 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year tf Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 112 28 9181 69 Director Nov 22, New York 1936 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No MD Howard Columbia Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 8787 Endless Ocean Way or Items 23a 21045 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? ★☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1959–64 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 📉 No Specify: Specify: 3 Widowed 4 Divorced natural Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) than Etementary/Secondary (0-12) College (1-4or 5+) if Health and Mental Hygiene. item 27 is marked other than other traumatic avent, Ins M Stock Broker <u>Financial</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Washington King, Sr. Flossie Toomer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jo Ellen Murphy/Partner 8787 Endless Ocean Way Columbia, MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of the Important: If its any injury or of once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Columbia Mem. Park * 4 ☐ Donation 5 ☐ Other (Specify) 9-2-2006 Clarksville, MD permit. 22 Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 21. Signature of Funeral Service Licensee Dur 0 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 0 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy 1 ☐ Yes of Vital 1 ☐ Yes 🙎 🖸 No 2 🔀 No the Hospital or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 🙀 No 2 ER/Outpatient 3 DOA in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 XNatural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 ho
To the Fune
completely fi (Check only one) and manner stated 29b. Signature and Mile of certifier 29c. License number 29d. Date signed (Month, Day, Year) -4113 August 29, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Dr. Knight 11065 Little Patuxent Parkway Columbia, MD 21044 31. Date filed (Month, Day, Year) State Registrar 2006

State of Maryland / Department of Health and Mental Hygiene 2008 29297 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Eileen A. Krause 30 2006 2:55 A August /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fairhaven Nursing Home Sykesville Carroll If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Aug 26, 1 Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** 1 □ M 20 F 009 10 4994 85 Director 1921 Massachusetts Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No MD Carroll Sykesville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7200 Third Avenue 21784 Itams 23e United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. Pages 1 and 2 should be filed within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: δ 3 Widowed 4 Divorced White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event, <u>once.</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Gaul Agnes Gallagher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lindsey Krause/Son 4937 Bramoton Parkway Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 8-30-2006 Catonsville, MD 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Light MQ1044 ww 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** neumania disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) burialattending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for 1 Yes 2 XNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has irector, page 2 s autopsy performed? 1 Yes 1 ☐ Yes 2 XNo 2XNo To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA this After thi funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No neral Director: , filled in by the f 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D34849 August 30, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road Eldersburg MD 1645 illiam Tan 32. Registr 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2005 29298 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** Anna Kuzmyak 9 2006 11:41 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring
If Under 1 Year If Under 24 Hrs. Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 1 □ M 2 N F Months Days Hours Min Yrs. Director 175-18-7161 84 3-14-1922 PA Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits e how rthen "natural", or items 23a or 28a-f eho the Medical Examiner must be notified at 1 Yes 2 ☐ No Director Cambria <u>Johnstown</u> the 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 314 Butler Ave. 15906 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 end 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 Widowed 4 □ Divorced Specify: White. 15. Decedent's Education 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) other then Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 27 le marked othe traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Kopach Julia Coukus ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Kuzmyak/Son 9509 Woodstock Court, Silver Spring, MD 20910 item 27 l 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Depertment of H Important: If its any Injury or ot once. 1 Burial 2 ☐ Cremation 3 Removal from State Grandview Cemetery 4 □Donation 5 □ Other (Specify) 9-7-2006 Johnstown. PA 22. Name and Address of Facility Harvey H. Zeigler Funeral Home 21. Signature of Funeral Service Licenses 23a. Part1. Inter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. (List only one cause on each line. Hyndman, PA 15545 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Bilateral Pneumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ettending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Day 4☐ Pregnant at time of death 5 Other (specify) ed by the detached P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? of Vital Records, δ Advanced Ovarian Carcinoma; Advanced Dementia 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Respiratory Failure; Bilateral Pleural Effusion has autopsy performed 1 🗌 Yes 2 No verel Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 Inpatient 2 □ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 Z No 3□ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division or Attending 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours eff To the Funerel Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) unda D53367 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rajan, Shyamsundar M.D. 9801 Georgia Ave, Suite 117, Silver Spring, MD 20910 31. Date filed (Month, Day, Year) SEP 0 5 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** August 25, Genevieve Louise Lindstrom 6:00 p 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Potomac If Under 1 Year Months Days Manor Care Potomac Montgomery

9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Y)
July 10, If Under 24 Hrs. 7. Age (In yrs. last birthday, **Funeral** 5. Social Security Number Year) Country, Michigan Min Hours 1 ☐ M 2 🛱 F 371-12-8304 84 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23e or 28a-f ehow many injury or other treumatic event, the Medical Evant for must be multiple 1 at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Directo Maryland Montgomery Potomac 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 20854 United States 10714 Potomac Tennis Lane Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: SpecifyWhite If Yes, Give Year or Dates: Completed by 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Baumgartner Mathilda Gehart P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gay Taylor/Daughter 10807 Pine Street, Fairfax, VA 22030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Fort Lincoln Crematory 8-30-06 ' 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD 22. Name and Address of Facility Simple Tribute, 1040 Rockville 21. Signature of Funeral Service Micense Pike, Rockville, MD 20852 I IY OCK 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Endstage Dementia Years /Medical Due to (or as a consequence of): Examiner Parkinson's Disease Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 1 I ive birth 2 Fetal death in the past 12 months?

1 Yes XXNo Day Month Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 ☐ Yes 2XXNo 3 ☐ Probably 4 ☐ Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? certificate 1 Yes 2 X No or Attending Physicien: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 1 Yes 2X No Certification: To 3□ DOA Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 X Natural 5 Pending 1 Tes 2 No 2 Accident investigation within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide 29a. Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D31319 August 28, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Loreto S. Albiol, M.D., 8218 Wisconsin Avenue, Ste. 305, Bethesda, MD 20814 31. Date filed (Month, Day, Year) 32 Registrar's Signature 3 0 2006 AUG Registrar

Please Type or Print in Black Indelible Ink

Maryland / Department of Health and Mental Hygiene

		- For State Registrar	Certificate of De		Reg	No. 200	6 2930			
Physicia edical Exami	.1117	1. Decedent's Name (First, Middle, Last) RODELL KYREE	LEE		2. Date of Death Month E August 24, 2	Day Year 2006	3. Time of Death 1612 hrs			
		4a. Facility Name (if not Institution, give street and number Shady Grove Adventist Hospital	· I	ity, Town, or Location of De		4c. County of Death Montgomery				
Funeral			o , , , , , , , , , , , , , , , , , , ,	Under 1 Year If Under 24		(MM/DD/YYYY) 9. Birth Foreign				
Director		214-53-3298 1 M 2 F	8 Yrs.	Ionths Days Hours I	July,	30,1998 ^{cou}				
v any	10a. State 10b. County 10c. City, Town or Location									
Maryland 28a-f show d at once.	į	MD Frederick 10e. Street and Number	Frederi	. Ck f. Zip Code	1100	. Citizen of What Coun	1 X Yes 2 No			
th the Mar 23a or 28s notified a	Director	22 North Pendleton C		21703		U.S.A.	. , ,			
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygene unt: If item 27 is marked other than "natural", or items 23a or 28a-f shown other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 Married Armed Forces	?lf Yes, s	cedent of Hispanic Origin? pecify Cuban, Mexican, Pu		14. Race - Americ White, etc.	an Indian, Black,			
ifter dea il", or i	by Fui	3 Widowed 4 Divorced If Yes, Give Year or Dates:	2 X No 1 Yes	s 2 X No specify:		Specify: B1	ack			
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5-0036 ted within 72 hours after the manual", the Medical Examiner	Completed	3rd	Stude			Elementa				
21215-0036 Muld be filed within 7 Mental Hygiene marked other than c event, the Medica	Be Co	17. Father's Name (First, Middle, Last) Robert E. Lee Jr			ame (First, Middle, Ma ristine	·				
212 ould be d Ments s mark lic even	To B	19a. Informant's Name/Relationship (Type, Print)		dress (Street and Number	or Rural Route Numb	er, City or Town, State,				
MD 2 sho salth and em 27 is raumatic		Christine D. Lee-Mothe	er 22 Nor	th Pendlet		ederick, 20c. Location - City or 1				
Baltimore, MD 21 permit Pages I and 2 should Department of Health and Me Important: If item 27 is mainury or other traumatic ex		1 Burial 2 Cremation 3 Removal from S		place)	/30/06	Germanto				
Baltimo permit Page Department of Important: injury or oth		Donation 5 Other Specify 21. Signature of Funeral Service Licensee	22. Name	and Address of Facility	snowden	Funeral H	ome, PA			
Physician	7	23a Part I. Enter the disease, or complications that cause		N. Washin			Approximate Interval			
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a. Drowning					Between Onset and Death			
, ,,		or condition resulting in death) Due to (or as a consequentially list conditions, b.	sequence of):							
¥	iner	if any, leading to immediate Due to (or as a conscause. Enter Underlying Cause	sequence of):							
ed	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a constitution)	sequence of):		** **		-			
760, icate be executed physician and the burial - transit	/Medical	d. UNPENDED AMENDED								
760, ficate be g physic s the bur	/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outco	ome of pregnancy	eath 3 Ectopic pre	egnancy	23d Date of delivery Month D	ay Year			
Sox 687 Jeath certific e attending p	Physician/	past 12 months?	at time a of all other	(Specify)	grancy	Moriai	ay roal			
O. E. the c		Part II. Other significant conditions contributing to dea	ath but not resulting in the unde	rlying cause given in Part I.	23e. Did toba	acco use contribute to the	he cause of death?			
S, P.C	Completed by					2 No 3 Proba				
cords, law requir has been s 2 should	plet				24a. Was an autopsy perform	prior to co	opsy findings available ompletion of cause of			
tal Rec cian: The certificate ector, page		25. Was case referred to medical		26.Place of Death (Ch	1 ✓ Yes 2		2 No			
Vita hysician this cer	To Be	examiner?	tient 2 ER/Outpatient 3	Othor		esidence 6 Other:				
n of Noting Ph		27. Manner of Death 1 Natural 5 Pending 28a. Date of In FOUND: FOUND:	FOUND:	y 28c. Injury at Work? 1 Yes 2 ✔ No	Subject drow	w injury occurred ned in pool				
ivision or Attene after death Director:	Certification:	2 ✓ Accident Investigation Aug 24, 200	06 1520 hrs Injury - At home, farm, street, fa	actory, office building, etc.	28f. Location (Str or Town, Sta	reet and Number or Run	al Route Number, City			
Divisior To the Hospital or Attenct within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide determined (Specify) St	wimming Pool		12700 Royal	Carriage Drive, G				
the Ho hin 24 the Fu	Medical	293. Certifier (Check only one) 2 Medical Examiner: On the basis of exam and manner stated	amination and/or investigation,							
0 = 0 = 1	l ĕ	29b. Signature and title of certifier	1000	29c. License number		29d Date signed (Mon	th, Day, Year)			
To with		1 1/1 1 1								
P S Note of P S No		30. Name and address of person who completed course of	death (Item 23a)	O.C.M.E.		August 25, 2006				
To To To Con		30 Name and address of person who completed cause of Carol Allan, MD Assistant Medical Exa		O.C.M.E. eet, Baltimore, MD 21		August 25, 2006				

			For State Registrer	State of Mar	yland /		artment rtificate			ind Me		jiene	71116	29	301
			1. Decedent's Name (First, Middle, Last)							- :	2. Date of Dea		Year	3. Time	of Death
	Physicia	_	Truc Van Le								Month August	27,		1:10	рм
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)			4b. City, 1	Town, or	Location of	f Death		4c. (County of Death	1	
			14319 Blackmon Dr	ive				Roc	kvill	le			Мо	ntgome	erv
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last b		If Under		If Under 2 Hours	24 Hrs. (8. Date of Birth (Month, Day	Year)	9. Birth	nplace (State untry)	
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	pur *	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation							10d, Inside	City Limits
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	ns 2	era	11. Marital Status	12. Was Decedent Ev	er in U.S.	13.	Was Decede	ent of His	spanic Orig	jin? (Spec	ify Yes or No-	1	4. Race - Amer		
36	72 hours after death with the Maryland Insturel; or Items 23s or 28s-f show Jical Esaminar must be notified at	by Funeral Director	1 ☐ Never Married 2 ★ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			fYes, speci 1 ☐ Yes 2	ify Cubar	Specify:	, Puerto R	lican, etc.)		Black, White SpecifASia		
Ö	2 hou		15. Decedent's Educ		16		dent's Usual					16b. Kir	nd of Business/I	ndustry	
715	7 nin 7.	pie	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	`		kind of wor DO NOT us			of working	9				
212	d with	Completed	8	College (1 401 34)			Owne	r			1	Rest	aurant		
b	at Hyger other	Bec	17. Father's Name (First, Middle, Last)						18. Mother	r's Name	(First, Middle,	Maiden .	Sumame)		
<u>la</u>	Venta Venta rked	To	Truong V. Le							Bao	T. Pha	am			
Maryland 21215-0036	od 2 sho lith and 1 27 is ma r trauma		19a. Informant's Name/Relationship (Type	pe, Print)	15	2002		Y 12				Dellex	Town, State, Z	01111111	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiene. Department of Heelih and Mental Hygiene. Bright in the m27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at Appea.		Yen Le/ Wife 20a. Method of Disposition ty□ Burial 2 □ Cremation 3 □ R.	emoval from State	сете	of Dispo tery, crer	ll9 Bl sition (Nam matery or ot morial	e of her place	a) Z	Augus	ite	20c. Lo	cation - City or	Town, State	_
臣	it. P.	1	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	98	Patkia					200	uneral		kville,	Maryla	and
Ba	Departiment of the particular		James & C	- los									e inc. Spring	MD '	20001
			23a. Part1. Exter the disease, or complic	cations that caused the	he death. D								ppring	Approxim	ate
	Physician		shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	End-Stage	e Rena		sease							Interval B Onset an	
	/Medical Examiner			Due to (or as a Diabetes			Type	11							
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequenc	e of).									
	cate be executed obysicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events	Essential	l Hype	rten	sion								
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9	certifica nding ph use as t	Med	IF FEMALE:	-									-		
O. Box	at the death certificate by the attending phys tached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal dea		Ectopic pre Other (spe					2	3d. Date of deli Month	ivery Day	Year
<u>ď.</u>	that the		Part II. Other significant conditions con	ntributing to death but	not resulting	n in the u	nderlying ca	use dive	n in Part I.		23e. Did to	bacco u	se contribute to	the cause of	f death?
ords,	w requires t been signe should be	ted by	Cerebral Artery Oc								1 🗆 Y	es 2[□No 3□Pro	obably 4 §	Unknown
of Vital Records,	The law requires ate has been sign page 2 should be	Completed								_	24a. Was a autop perfor		death?	topsy finding completion of 2 \(\text{No} \)	s available cause of
ta		0	25. Was case referred to medical						26. Place	of Death	(Check only or		1 100	20,10	
<u> </u>	Physician: this certific ral director,	OB	examiner? 1 Tes 2 No	lospital:	2 ER/	Outpatier	nt 3□ DO	A Othe	c				i □Other (Spec	cify)	
	ding After fune	tion; T	27. Manner of Death 1	28a. Date of Injury (Month, Day	Year) 28t	D. Time of Injury	f 28	8c. Injury Work	at ? ′es 2 □ N		8d. Describe h	ow injury	occurred /	,,	
Division	in Die	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, (Specify)	farm, str	reet, factory	, office		2	8f. Location (S City or Tow		d Number or Ru	ral Route No	umber,
_	urs urs eral	edical Co	(Check only 2 Medical Examir	sician: To the best of ner: On the basis of e	examination .	ige, deat and/or in	h occurred a	at the tim in my op	e, date and inion, deat	d place, ai	nd due to the o	ause(s) late and	and manner as place, and due	stated. to the cause	9(s)
	To the Host within 24 ho To the Func completely f	Med	29b. Signature and title of certifier	and manner state			29c	. License	number			29d. Date	a signed (Monti	1. Dav. Year)
	2 ½ Ç Ö	-	. M	71.11		N =	1		-	220		α			
7	4	0.4	Cynthia m		-			700	580	コン	,	····	gust 2	20, 2	UUB
			30. Name and address of person who co Cynthia Williams,	D.O. 600	01 Mun	cast	er Mi	11 F	Road,	Rock	ville,	MD	20855		
	Sta Registi		31. Date filed (Month, Day, Year) AUG 3 0 20	32 degistrar	's Signature	1	arte								

State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Harry LASKIN 26, 2006 1:00 A August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wilson Health Care Center Gaithersburg Montgomery If Under 1 Year If Under 24 frs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 579-22-5899 88 Hours 1**X** M 2□ F Yrs. Director June 20. 1918 Washington, Usuel Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 end 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If item 27 is marked other then "naturel", or Itema 23a or 28e-1 ehow ury or other fraumatic event, the Mudical Examinatoriast be notified at 1 ☐ Yes 2 No Rockville Maryland Montgomery Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 10201 Grosvenor Place #1205 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1X Yes 2 □ No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7/ th and Mental Hygiene. 7 is marked other then "n Elementary/Secondary (0-12) College (1-4or 5+) Warehouse Supervisor Giant Food 9 17. Father's Name (First, Middle, Last)
Samuel Laskin 18. Mother's Name (First, Middle, Maiden Sumame) Be Anne Azersky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20307 Crown Ridge Court, Germantown, MD Marc Nathan, Grandson 20b. Pface of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 08/29/06 Department of Important: If its eny injury or or once. 1 ∑Burial 2 ☐ Cremation 3 ☐ Removal from State Judean Memorial Gardens 4 ☐Donation 5 ☐ Other (Specify) Olney, MD 21. Signature of Funecal Service Licensee 22. Name and Address of Eacility
Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 Approximate fnterval Between Onset and Death 23a. Part 1. Enter the disease, or compfications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. fmmediate Cause (Finat Vascular **Physician** prebal disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner <u>cranial</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physicien and s the burial-transit The law requires that the death certificate be executed Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physiclan/Medical as attending I IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐ Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cerebellar he 1 Yes 2 No 3 Probably 4 Maknown neumonia 24b. Were autopsy findings available prior to completion of cause of death? has autopsy perform Acter Coronaren 1 ☐ Yes 2 No 1 Yes I or Attending Physician: after death. Director: After this certifice : After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other. Nursing Home 5 Residence 6 Other (Specify) 2 DNO ို 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be within 24 hours after de To the Funeral Director completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Dav. Year) 10+ 10059453 August 29 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Naid Feinberg Russell Av raithers burg 201

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

AUG

3 0 2006

32. Pegistrar's Signature

			For State Registrar	State of Maryla	•	artment of I rtificate of			giene Reg. No. 20 (06	29303
	Dhysisi		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day \	Year	3. Time of Death
	Physici /Medic	al	Victor		arles	Luni			30, 2006		7:00 P M
	Examin	er	4a. Facility Name (If not institution, give s 15505 Winslow St	•			or Location of Deat berland	tn		legan	у
4	Funeral Director		5. Social Security Number 6. Sex		rs. last birthday) Yrs.		If Under 24 Hrs			Country	ce (State or Foreign ornia
	and * *		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation				10d	I. Inside City Limits
	Maryl -f sho fied a	tor	MD Alle	gany		Cumberla	.nd				1 ☐ Yes 2 🛣 No
	or 288	Director	10e. Street and Number			10f. Zip Code	0.4=00		10g. Citizen of Wh		17
	e 23a		15505 Winslow S		-11.6	Mar Dander of	21502	Coopily Ven or No	US.	A - American	Indian
936	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or lieme 23a or 28a-f show event, the Mydical Examinar must be mailfied at	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 X Yes 2 □ No 1 If Yes, Give Year or Dates: 1 		Was Decedent of If Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puer Specify:	to Rican, etc.)		White, etc.	э.
2-0	72 hou	Completed	15. Decedent's Educ (Specify only highest grade		16a. Dece	dent's Usual Occu	pation during most of wo	orking	16b. Kind of Busi		
121	han .	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	9d)	9	Tina -	nod Die	ah h a sa
d 2	filed v Hygie other t		12 17. Father's Name (First, Middle, Last)	22		Office N		me (First, Middle,	Tire a		ibber.
/an	Aental Aental rked c	To Be	Theodore	Lui	ning		Irene			Bin	ard
Maryland 21215-0036	ges 1 and 2 should be filed v t of Health and Mental Hygie If Item 27 is marked other t or other traumatic event, ID		19a. Informant's Name/Relationship (Type				t and Number or A				
e, 2	0 = 0 =		Elizabeth A. Lunin 20a, Method of Disposition			b Winsion (Name of	Street,	Date	20c. Location - C	2150 city or Towr	
nor	ages ant of I it: If It y or o		1 X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, cre	matory or other pla	ocky Gap	09/05/20		′	
Baltimore,	permit. Pages 1 and Department of Healt Important: if Item 2 any Injury or other 2006.		21. Signature Furl ral Service License				ess of Facility Ac				
<u> </u>	Dep. Impo		Liber C. C	elone			tur Stree				1502
	Physician		23a. Part1. Enter the disease, or complishook, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the cause on the line.	leath. Do not en	iter the mode of dy	ing, such as cardia	c or respiratory ar	rest,	1r	pproximate interval Between Dinset and Death
1	/Medical Examiner		Tosulary an dodn'y	Due to (or as a con	sequence of):	100	Same	fin	•		Lule of C
		ner	Esquantially list conditions, if any, leading to immediate cause. Enter Underlying	ue to (or as a co	sequence of):	[10]	jui	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			Weeks
	ate be executed thysician and the burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con	sequence of):						
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9	ate the	ledical		J.				-	- 1		
Box	dea h certific e at ending p id for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pre 1 Live birth 2 ☐ F	etal death 3	⊒Ectopic pregnan	су		23d. Date Mont	of delivery	ay Year
0.	he dea the al	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time 9☐ Unknown	of death 5[Other (specify)					
s, P.	law requires that the de as been signed by the a 2 should be detached	by Ph	Part II. Other significent conditions cor	ntributing to death but not	resulting in the u	underlying cause g	ven in Part I.	23e. Did to	obacco use contrib	oute to the	cause of death?
ords	w require been sig should b							1 🗆 \	es 2 No 3	Probab	oly 4 Unknown
of Vital Record	9 4 8	ompleted						24a. Was autop perfo 1 Yes	rmed? pr	ere autops lor to comp ath? Yes 2	y findings available bletion of cause of
/ita	ician: Th certificate ector, pag	BeC	25. Was case referred to medical examiner?	La catali				eath (Check only o			
of	this aldir	- To	1 ☐ Yes 2 No 27. Manner of Death		2 ER/Outpatie	III 3 DOA		Home 5 Resid	dence 6 Other	-	
Ion	Attending r death. ector: After by the fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yea	r) Injury	W	ork? ∃Yes 2 □No		,,	_	
Division	pital or Attending Fours after death. ieral Director: After filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.	At home, farm, st ecify)	treet, factory, office)	28f. Location (S City or Tov	Street and Number vn, State)	r or Rural F	Route Number,
	To the Hospital or A within 24 hours after To the Funeral Directorpletely filled in b.	edical (sician: To the best of my ner: On the basis of exar and manner stated.							
	To the vithin To the comp	Me	29b. Signature and title of certifier	2/0/1	2	29c. Licer	nse number		29d. Date signed		
•	4/100		1 //		-10		13601		August	31, 2	2006
	71 LS		30. Name and address of person who co Victor Felipa				rive, Cu	mberland.	MD 215	502	
	A STATE OF THE PARTY OF THE PAR	ate	31 Date filed (Month Day Year)	32 ABenistrar's S	ignature						
1	Regist	rar	AUG 3 1 200	O Marie	M. On	500,000 B					

			101	•	artment of Health and M tificate of Death		ene g. No. 200 (5 29304
	Physici		1. Decedent's Name (First, Middle, Last) Leo Marcellus Lease			2. Date of Death Month		3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number) MEMORIAL HOSPITAL		4b. City, Town, or Location of Death CUMBERLAND		4c. County of Deat	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birt 215-36-9670 1 M 2 F 66	thday) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, 12-15-1	Year) Co	hplace (State or Foreign untry)
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town MD Allegany Nount.			12=13=1	7.37	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	th with the 23s or 28s	al Director	10e. Street and Number 14509 Delbrook Lane NW		101. Zip Code 21545	10	g. Citizen of What Co	untry?
2-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23s or 28s-f show any injury or other traumatic event, I're Medical Examinating rates by mullified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes, 2 ☑ No If Yes, Give Year or Dates:	lf.	Vas Decedent of Hispanic Origin? (Spi Yes, specify Cuban, Mexican, Puerto Yes 22 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
0-61212	l within 72 ho iene. rthen "natur ihe Mevicel	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. D	lent's Usual Occupation kind of work done during most of work DO NOT use retired) ipment Operator	ng	6b. Kind of Business/	
ylandz	ould be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Last) Frank Marcellus Lease	Lyw	18. Mother's Name	(First, Middle, M		
re, mar	1 and 2 shi Health and tem 27 is m		Leo Lease Jr / Son 1 20a Method of Disposition 20b. Place of	2 31 :	g Address (Street and Number or Rura 5 Arrow Dr., Mt., sition (Name of	Savage, 1		
gaitimore,	ermit. Pages epertment of nportant: If I ny Injury or on		1 Z Buriai 2 Cremation 3 Z Hemoval from State		emetery 8-26. Name and Address of Facility Ha	-2006 wey H. :	Madley, P Zeigler Fu	A neral Home
	Physician		23a. Part Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	not ente	69 Clarence St.,	lyndman,	PA 15545	Approximate Interval Between Onset and Death
8/60,	/Medical physicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of	of):	-	NO51.	S	I WEEK
O. BOX 68/	ures thet the death certificate signed by the attending phy d be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \ Yes 2 \ No 9 \ Unknown \		Ectopic pregnancy Other (specify)		23d. Date of deli Month	very Day Year
rds, r	w requires thet been signed b should be deta	ρ	Part II. Dther significant conditions contributing to death but not resulting in	the un	nderlying cause given in Part I.	23e. Did toba	acco use contribute to	
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DIVISION OT VITAL	ng Phys fter this ineral di	Certification; To Be	Natural 5 Pending (Month, Day Year) Ir 2 Accident investigation 3 Suicide 6 Could not be	Time of njury	28c. Injury at Work? M 1 Yes 2 No	me 5 Residen 28d. Describe how	nce 6 ∐Other <i>(Spec</i> v in∤ury occurred	
2	To the Hospitel or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	sai Certif	4 Homicide determined building, etc. (Specify) 29a. Certifier Scentifying Physician: To the best of my knowledge	o, death	occurred at the time, date and place	City or Town,	use(s) and manner as	stated
		Medicai	(Check only one) 2 Medical Examiner: On the basis of examination and and manner stated. 29b. Signature and title of certifier	Jor inv	29c. License number	יסני	d Date signed (Most)	
	5		30. Name and address of person who completed cause of death (Item 23a) (William Lamm MB 900	Type, F	Print) Ton Drive Cur	abeala	ad MI	21502
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 8 2006	San-	de	Neria	W / 101.	2.002

Amanda Michelle Lipka

Please Type or Print in Black Indelible Ink

1 loude Type of Time III Elder III and			
State of Maryland / Department of Health and Me	ental Hygiene		
Certificate of Death	Reg. No.	2006	29305
- /Fina Baildin Look)	2 Date of Death	3 Tim	e of Death

		1- For State Registrar	Certificat	e of Death		,,,	Reg.	No.	200	6 2930
Physicia	an/	Decedent's Name (First, Middle,Last)			-	Mo	te of Death	ay	Year	3. Time of Death
edical Exami	ner	Amanda Michelle Lipka				Se	otember 6	5, 2006	3	1927 hrs
		4a. Facility Name (if not institution, give street and number)		4b. City, Town	n, or Location of D)eath		4c. Coi	unty of Death	
		39 Elwoods Road	/h last binth			AUro TO D	eta of Pieth			place (State or
Funeral Director		5. Social Security Number 6. Sex 7. Age 17. Ag	e (In yrs. last birthd			Min.	pril		Foreign	
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death with the Maryland or items 23a or 28a-f she must be notified at once	Funeral	11. Marital Status 1 X Never Married 2 Married Armed Forces?			uban, Mexican, Pu				White, etc.	an indian, black,
er dea		3 Widowed 4 Divorced If Yes, Give Year	X No	1 Ves 2 V	No specify:			Spe	ecify Whi	to
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)36 hin 7 than edica	g	11	Н	omemaker				Own	Home	
d wit ygien ygien other he M	Ö	17. Father's Name (First, Middle, Last)		<u> </u>	18.Mother's N	Name (First,	Middle, Mai			
21215-0036 uld be filed within 72 Mental Hygiene marked other than 'e event, the Medical	Be (Scott M. Lipka			Heidi	i J. K	ilhe f.	ner		
MD 21215-0036 1.2 should be filed within 72 hours after this and Mouta Hygiene at 77 is marked other than "natural", committe event, the Medical Examiner:	2	19a. Informant's Name/Relationship (Type, Print)	19b.	Mailing Address (S						
e, MD 2 and 2 shoul Health and N item 27 is m		Scott M. Lipka/father		37 Frankl		2 , Por	t Dep	osit	, MD :	21904
2 2 2 2		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from Sta		Disposition (Name or y or other place)	of cemetery,	Date - 09 - 09	2006	20c. Loca	ation - City or T	own, State
Pages ent of nt: 1		4 Donation 5 Other Specify:						Ris	ina Sui	n, Maryland
Baltimore, permit. Pages I at Department of Hee Important: If ite		21 Seriative of Funeral Service Licensee	4.	22. Name and Add	dress of Facility	2.T. F	oard	Fune	ral Hor	ne. P.A.
E.E.G.B.	- 3	Buchard T. Clovel	ce _	1 111 S.	Queen St	t., Ki	sing.	Sun,	MU 2	1911
Physician		23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each inc.	the death. Do not	enter the mode of dy	ying, such as card	diac or respi	ratory arrest	t, shock,	or heart	Approximate Interval Between Onset and
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Box 68760, death certificate be he attending physic of for use as the bur do ruse as the bur		IF FEMALE: 23c. If yes, outcor	me of pregnancy						ate of delivery onth D	ay Year
Ox 68 ath certifi attending or use as	ä	past 12 months?	time of death 5	Fetal death Other (Specify)	3 Ectopic p	regnancy		IVIO	nth D	ay teal
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that the d red by the		Part II. Other significant conditions contributing to deat	h but not resulting	in the underlying cau	use given in Part	1. 2	3e. Did toba	acco use	contribute to t	he cause of death?
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Division of Vital Records, tat or Attending Physician: The law require as pier death. al Director: After this certificate has been si led in by the funeral director, page 2 should the control of the pier of the control of the cont	Certification:	3 Suicide 6 X Could not be	found in mo			Nor	or Town, Star th Fast	te) 39 - MD	Elwoods	al Route Number, City Drive
lospi 4 hou uner		29a, Certifier 1 Cartifuing Physicians. To the best of m	ıv knowledge, deat	h occurred at the tim	ne, date and place					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one) 2 Medical Examiner: On the basis of exa	mination and/or in	vestigation, in my op	oinion, death occu	irred at the t	ime, date ar	nd place,	and due to the	e cause(s)
F	Me	29b. Signature and title of certifier		29c. Li	icense number		1	29d. Date	e signed (Mon	th, Day, Year)
		Patulle - Holds	~	c	D.C.M.E.			Septer	mber 7, 200	06
		30. Name and address of person who completed cause of	death (Item 23a)	1						
	i.	Patricia Aronica-Pollak MD. Assistant M	/ledical Exami	ner 111 Pen	n Street, Balt	imore, M	D 21201			
	tate	31. Date filed (Month Pay Year) 1 2006 32. Resistra	ar's Signature	Sperke						
Regis	strai	JLI 2000	was D.	7						

			1 - For State Registrar	State of Marylan	•	artment of			giene Reg. No. 20	06 29306
I	Physici /Medic		Decedent's Name (First, Middle, Last BETTY M		CKENZ	IE		2. Date of De Month Augus	ath Day	3. Time of Death Year
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Dea	ath	4c. County	
			Casey House				kville			ntgomery
	Funeral		5. Social Security Number 6. Se	TH OFFICE		If Under 1 Year Months Days			th ly, Year)	Birthplace (State or Foreign Country)
	Director		216-22-1470 Usual Residence of Decedent	82	Yrs.			Dec.2	,1923	Maryland
	and w		10a. State 10b. County	10c. Cit	y, Town or Lo	cation			.,	10d. Inside City Limits
	f sho	5	MD Montgo	moru	Di	ckersor				1X Yes 2 ☐ No
	the 28s	Director	10e. Street and Number	mery	DI	10f. Zip Code	1		10g. Citizen of W	/hat Country?
	3a oi	Ö	20900 Big W	oods Road			20842		U.S.A	٨.
	ms 2	Funerai	11. Marital Status	12. Was Decedent Ever in U.	S. 13.	Was Decedent of		(Specify Yes or No erto Rican, etc.)		- American Indian,
9	or Ite	F	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2X No		1 ∏ Yes 2 D∛ No		nto rican, etc.)		k, White, etc. : Black
93	ours Fraff,	d by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:		103 21210			Зреспу.	DIACK
21215-0036	within 72 hours after deeth with the Maryland ane. then 'natural', or Items 23s or 28s-f show he Mudical Execution mail to indiffed at	Completed	15. Decedent's Edu (Specify only highest grad	ucation de completed)	(Give	dent's Usual Occu kind of work done	during most of w	orking	16b. Kind of Bu	siness/Industry
2	vithin hen	m	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire	,	L	Dant	of Tubowion
7	Hygie Hygie Sther I		12th 17. Father's Name (First, Middle, Last)		CO.	присег	Analysi	L ame (First, Middle		of Interior
and	od be	Be C	UNKNOWN					tavia W		•
Maryland	should be filed within 72 hours after deeth with the Marylan nd Mental Hygiene marked other then "natural", or Items 23a or 28a-f show unatic event, the Medical Exaction mat be notified at	ဥ	19a. Informant's Name/Relationship (T	vpe. Print)	19b. Mailir	na Address (Stree		Rural Route Numb		
N S	alth ar		Ida Hallman- C	ousin	209	00 Big	Woods 1	Rd Dick	erson,	MD 20842
ore,	Tite of He		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	1 0	lace of Dispo	sition (Name of matory or other pla	ace)	Date	20c. Location · (City or Town, State
Ĕ	ant: and		4 ☐ Donation 5 ☐ Other (Specify,) Me		nrl Svo		1/06		dria, VA
Baltimore,	permit. Peges 1 and 2 should by Deperment of Health and Monta Important: If item 27 is marked eny injury or other traumatic engage.	0	21. Sign ture of Funeral Service Licens	iee /						l Home, PA
	ucz e u		23a. Part1. Enter the disease, or comp	dications that caused the deat						Approximate
	Dhusisian		shock, or heart failure. List only of Immediate Cause (Final	one cause on each line. END STAG				,		Interval Between Onset and Death
È	Physician /Medical		disease or condition resulting in death)	a Due to (or as a consequence						
ı	Examiner		Sequentially list conditions,	b						
	be at sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Qualito (or as a consequ	uanca of):					
_6	s be executed sician and burial-transit	хап	that initiated events resulting in death) Last	c. Due to (or as a consequ	uence of):					
760	ite be executed sysician and he burial-transit	icai E		d						
68			in equip	118 - 178 - 118						
ŏ	th cer lendir r use	an/N	230. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnanc	cv			e of delivery
P.O. Box	the at	Physician/Med	in the past 12 months? 1 □ Yes 2 █ No 9 □ Unknown	4☐ Pregnant at time of de 9☐ Unknown	eath 5	Other (specify)			Mon	nth Day Year
	ires that the death certifica signed by the attending ph d be detached for use as th	/ Ph	Part II. Other significant conditions co	entributing to death but not res	ulting in the u	nderlying cause g	iven in Part I.	23e. Did 1	obacco use contri	ibute to the cause of death?
Division of Vital Records,	Physicien: The law requires that the death certifica this certificate has been signed by the attending of rail director, page 2 should be detached for use as it	ed by						10	Yes 2∕ΩNo	3 ☐ Probably 4 ☐Unknown
000	as been si 2 should	Completed						24a. Was	an 24b. W	Vere autopsy findings available rior to completion of cause of
Ē.	hysicien: The law his certificate has t I director, page 2 s	Con						perfo 1 ☐ Yes	ormed? d	eath? □ Yes 2XX No
/ita	clen: entific ector,	Be	25. Was case referred to medical examiner?	U				eath (Check only		
of o	Physical this call direction	2	1 ☐ Yes 2€ No 27. Manner of Death		ER/Outpatier	IL SEL DON		-		or (Specify)Hospice
UQ	ding h. After tuner	tion	1X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	We	ork?]Yes 2.∐No	280. Describe	how injury occurre	3 0
İSİ	I or Attending efter death. Director: After d in by the fune	fica	3 Suicide 6 Could not be	28e. Place of Injury - At ho	ome, farm, str					er or Rural Route Number,
á	s efter s efter s of in Dire	Certification;	4 Homicide	building, etc. (Specify	y)			City or To	wn, State)	
	To the Hospitel or Attending Ph within 24 hours effer death. To the Funeral Director: After th completely filled in by the funeral	cai	29a Cartifier	prictant To the best of my kno iner: On the basis of examina and manner stated.	wladge, death tion and/or in	vestigation, in my	ina, date and pla opinion, death oc	os and dus to the curred at the time,	date and place, a	iner as stated and due to the cause(s)
	To the within 2 To the complet	Medi	29b. Signature and title of certifier			29c. Licer	ise number		29d. Date signed	(Month, Day, Year)
	1		Cipithie 7	n Wellen		ноо	58032		Augus	t 28,2006
	Q		30. Name and address of person who co	completed cause of death (Item	1 23a) (Type,	Print)				
			Cynthia M. Wi	11iams, DO 32. Signar's Signa	6001	Muncast	er Mil.	L Rd Ro	ckville	, MD 20855
	Sta Registi			2006 Jaguer 2	B. A	03450				

			- roi	artment of Health and Mental tificate of Death	Hygiene 2006 29307
			Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of	Neg. 140.
	Physicia	an		Month	
,	/Medic		4a. Eecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1	Examin	er	Papinsula Regional Medical Center	Colistany	Wicomica
	Funeral		5. Social Security Number Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Unger 24 Hrs. 8. Date of Months Days Hours Min. (Month	of Birth 9. Birthplace (State or Foreign
	Director		220-52-0221 10M 20F 56 Yrs.	Months Days Hours Min. (Month	28-1950 New YORK
	p ,	ſ	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	oction .	10d. Inside City Limits
	aryla •hov	2	MD Wiconico Salist		1 4es 2 No
	Me M	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	with t		INC FI	2180	1 C A
	eath	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. y	Was Decedent of Hispanic Origin? (Specify Yes	or No. 14. Race - American Indian,
	fter d	표	1 ☐ Never Married 2 Married 1 ☐ Yes 2 No	Was Decedent of Hispanic Origin? (Specify Yes of Yes, specify Cuban, Mexican, Puerto Rican, etc	DI
3	filed within 72 hours after death with the Maryland Hygien. Hygien, interest or Items 23s or 28s-f show int, the Miclical Examinar must be notified at	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	Specify: Black
ر م	72 hc	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working	16b. Kind of Business/Industry
2	Athin	dr.	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	Comfech
N	lled v tygie thert	ပိ	17. Father's Name (First, Middle, Last)	Laborer 18. Mother's Name (First, M.	iddle Maiden Sumame)
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelih and Mental Hygiene. Important: if them 27 is marked other than "naturel; or Iteme 23a or 28a-f show important: if them 27 is marked other than "naturel; or Iteme 23a or 28a-f show eny injury or other traumatic event, the Micdical Examinar must be notified at ODGs.	To Be	LEMUEL F. MOORE	Alice (onguesT
ary.	shound Mind Mind Mind	۲		ng Address (Street and Number or Rural Route N	
Š	elth a		Arlene Moore - Wife 1218		Burg ND 21801
ore	of He of He f Item r oth		20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State	sition (Name of Date natory or other place)	20c. Location - City or Town, State
Ĕ	Pag ment ant: f ury o		4 Donation 5 Other (Specify) Waltsuille	Comedery 08-29-0	6 Virginia
Baltimore,	ermit. Depert mport ny Inj		21. Signature of Funeral Service Licensee	Name and Address of Facility	ineral Home
	anzea		23a. Part1. Enter the disease, or complications that caused the death. Do not ent	or the mode of thing such as cardiac or resourate	Princess Ann MD 21853 ory arrest. Approximate
			shock, or heart failure. List only one cause the line.	si (ne mode or dying, such as cardiac or respirate	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a. District as a consentency of:	ardio	
	Examiner		Metaboliz	- Azidosio	
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	, , , , , , , , , , , , , , , , , , , ,	
	ocuted nd transi	Examiner	Cause (Disease or injury that initiated events c.	1 Sion	
00	oe execian a		resulting in death) Last Due to (or as a consequence of):		
8760,	The law requires that the death certificate be executed sie has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	d		
9 X	certifi ding ise as	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
Вох	atter d for u	clar	In the past a months? 4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)	Month Day Year
Р. О.	t fhe c by the	hys	9 Unknown		
e,	w requires that the death certific been signed by the attending p should be detached for use as	by P	Part II. Other significant conditions contributing to death but not resulting in the u	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Did tobacco use contribute to the cause of death?
ğ	equire en si ould t	ted	sid heres Mer 11+as	<u> </u>	1 Yes 2 No 3 Probably
Division of Vital Records,	law rias be	Completed	Chronic Ridney Dis		Was an autopsy findings available prior to completion of cause of
Ξ Έ	ilcien: The lav certificete has rector, page 2	Con	J	101	performed? Yes 2 No 1 Yes 2 No
/ita	clen: ertific ector,	Be	25. Was case referred to medical examiner?	26. Place of Death Check of	only one)
of	Physic this c	. To	1 ☐ Yes 2 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatier 27. Manner of Death 28a. Date of Injury 28b. Time of		Residence 6 Other (Specify)
ם	ding h. After funer	tlon	Natural 5 Pending (Month, Day Year) Injury	8 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	and the many occurred
isi	Attending Physicien: Ir death. ector: After this certifice by the funeral director, I	flca	3 Suicide 6 Could not be	reet, factory, office 28f. Locat	tion_(Street and Number or Rural Route Number,
á	s efter	Certification:	4 Homicide determined building, efc. (Specify)	City o	or Town, State)
	hours unere	edical (29a. Certifier (Check only (Ch		
	To the Hospitel or Attending Physicien: The i within 24 hours eliter death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Medi	29b. Signature and till a politicar A	29c. License number	29d. Date signed (Month, Day, Year)
	N I S		* Vall W		The state of the s
,		,	30. Name and address of person who completed cause of death (lter) 23a) (Type,	Print)	174yusi 23,0006
		1	STEVEN Homlette M.D.	, 100 E Carroll S	August 23,2006 T. SAlisbury MD
	Sta		31. Date filed (Month, Day, Year) AUG 3 1 2008 32. Registrar's Signature	Signite !	
	Regist	ar	MOG 9 I TOOG JACOBOO JA	y was	

220-53-0321

MONNIE MODRE

			1- State of M	aryland / Do	epartment of Hea Certificate of Dea	lth and Menta ath	al Hygien Reg. N		29308
	D		Decedent's Name (First, Middle, Last)				ate of Death	ay Year	3. Time of Death
	Physici /Medic		DENNIS		MAYNARD	Au	gust 21	0 2006	13:22 PM
	Examin	er	4a. Facility Name (If not institution, give street and number	Hoant	4b. City, Town, or Local	ation of Death	, 4	C. County of Deat	MINE
	Funeral			ge (In yrs. last birth		Under 24 Hrs. 8. Da	te of Birth	9. Bird	thplace (State or Foreign puntry) Kitts, WI
	Director		580-27-4215 XDM 2DF	48 Y	rs.	Jur	ne 27,	1958 St.	Kitts,WI
	land w		Usual Residence of Decedent 10a. State 10b. County West	10c. City, Town	or Location				10d. Inside City Limits
	a-f eh	ctor	Indies N/A	Christ	iansted				1 XYes 2 ☐ No
	vith the	Director	10e. Street and Number	0060	10f. Zip Code	0		Citizen of What Co	ountry?
	leath v	Funeral	276 Work & Rest, P.O. Box 11. Marital Status 12. Was Deceden		00823-826 13. Was Decedent of Hispar	nic Origin? (Specify Y	es or No-	. S . A .	encan Indian,
21215-0036	d within 72 hours after death with the Maryland liene. r than "naturel", or liems 23a or 28a-f ehow the Macical Examinat must be mullified at	þ	1 Wever Married 2 Married 1 Yes 2 1 Yes 3 Widowed 4 Divorced Armed Forces 1 Yes 6 2 1 Yes 6 3 1 Yes 6 2 1 1 Yes 6 2 1 1 Yes 6 2 1 1 Yes 6 2 1 1 Yes 6 2 1 1 1 Yes 6 2 1 1 1 Yes 6 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	? No	If Yes, specify Cuban, M	exican, Puerto Rican, pecify:	, etc.)	Black, Whit	
2-0	72 ho natur	eted	15. Decedent's Education (Specify only highest grade completed)		Decedent's Usual Occupation Give kind of work done during	g most of working	16b.	Kind of Business	/Industry
121	iene. than	Completed	Elementary/Secondary (0-12) College (1-4or	5+) _	life. DO NOT use retired) hef		I	Hess	
1d 2	∰ Y € ±	w	17. Father's Name (First, Middle, Last)		18.	Mother's Name (First	t, Middle, Maide	an Surname)	
ylar	should be ind Mental s marked o umatic ave	To B	Joseph Archibald			ardie Mayr			
Maryland	es 1 and 2 should bot Health and Menti fitem 27 is marked rother traumatic a		19a. Informant's Name/Relationship (Type, Print)		Mailing Address (Street and I				
di	Healt Healt tem 2		Dennise R. Maynard (daug) 20a. Method of Disposition		33 Oberlin Ci Disposition (Name of crematory or other place)	rcie, Frec		MD 2170 Location - City or	
OW	Pages ient of nt: If i		1 ☐ Burial 2 ☐ Cremation 3 🎞 Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	3 1	ary's Parish		St.	. Kitts.	West Indies
Baltimore,	permit. Pages 1 Department of H Important: If Ite eny Injury or of once.		21. Signature of Funeral Service Lipensee	sson	22. Name and Address of 7400 Georgia		Funera	al Servi	ce
			23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	ed the death. Do no	·			•	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	રે ડ					1WO DAYS
	/Medical Examiner		963	s a consequence of		170.1			There Were
		Jer	if any, leading to immediate Due to (or a	s a consequence of	TERIAL INFE	CILON			THREE WEEKS
	icuted nd transit	Examine	that initialisa syonis		<i>AESERENTIT</i>	75			1 mouth
8760,	cate be executed physicien end the burial-transit	EX	resulting in death) Last Due to (or a	s a consequence of	f):				
87		edical	d						
.O. Box (The law requires that the death certifi ate has been signed by the attending I page 2 should be detached for use as	Physician/Me		e of pregnancy 2 Petel death at time of death	3 Ectopic pregnancy 5 Other (specify)			23d. Date of de Month	livery Day Year
Δ.	quires that in signed by aid be deta	þ	Part II. Other significant conditions contributing to death	but not resulting in	the underlying cause given in	Part I. 2	3e. Did tobacco		o the cause of death? robably 4 Munknown
Records,	The law requir cate has been si page 2 should	Completed					4a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
Vital	Physician: T this certificat ral director, pa	Be	25. Was case referred to medical examiner?			Place of Death (Che	ock only one)		
of	Physic rthis c ral dir	7	1 ☐ Yes 2 No Rospital 1 Inpa 27. Manner of Death 28a. Date of In	tient 2 ER/Outp		Nursing Home 5	5 Residence Describe how in		icify)
ion	Attending I or death. ector: After by the funer	atlon	1 Natural 5 Pending (Month, D	ay Year) In	me of 28c. Injury at Work? M 1 □ Yes	2 🗆 No			
Division	al or Attendi s after death. Il Director: A ed in by the fo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of 1 building.	njury - At home, far etc. <i>(Specify)</i>	m, street, factory, office		ocation (Street a bity or Town, Sta		ural Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical (29a. Certifier (Check only one) Certifying Physician: To the besing and manner:	t of my knowledge, of examination and stated.	death occurred at the time, ditor investigation, in my opinion	late and place, and di on, death occurred at	ue to the cause the time, date a	(s) and manner as ind place, and du	s stated. e to the cause(s)
	withi To tl	Ž	29b. Signature and title of certifier	1	29c. License nu		1 .	Date signed (Mont	
•	5		1////	Thonre,		5-000		gust 20	
			30. Name and address of person who completed cause of Bonnie Lenze, MD		600N. Wolf	e St Bal	Hmon	e MD ?	21287
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) AUG 3 0 2006	strar's Signature	Sperke				

mended :	ite	For State MF Registrar 2 per physi	State of Maryland / Departician, 8/30/2006 Ce		D, D.H. Reg. N		29309
Physici	^	1. Decedent's Name (First, Middle, Last) Ross William Med1:	ar		2. Date of Death Month D	2006 Year	3. Time of Death
/Medic Examir	400	4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Death		c. County of Death	1007
	_ < _**	Atlantic General		Berlin		Worceste	
Funeral		5. Social Security Number 6. Sex	M 0005	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	ir) Coul	
Director		Usual Residence of Decedent	62 Yrs.		7/21/1944		NY
yland		10a. State 10b. County	10c. City, Town or Lo	ocation			Od. Inside City Limits
e-f st	ctor	MD Worce	ster Ber	lin			1 ☐ Yes 2 ☐ No
or 28	Director	10e. Street and Number		10f. Zip Code	10g. (Citizen of What Cou	ntry?
s 23s		140 Pine Forest D		21811 Was Decedent of Hispanic Origin? (S	pacify Yas or No-	USA 14. Race - Ameri	can Indian
72 hours after death with the Marylan 72 hours after death with the Marylan natural; or Items 23s or 28e-f show Jes. Examinet and the notified at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married	Armed Forces? 1 X Yes 2 ☐ No	If Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	Black, White,	
urs af	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates: 1969-70	1 ☐ Yes 2 🔯 No Specify:		Specify: Wh:	ite
72 ho	Completed	15. Decedent's Educ (Specify only highest grade	(Give	dent's Usual Occupation kind of work done during most of wor	king 16b.	Kind of Business/In	dustry
within lene. than	np.	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)		Education	
be filed within 72 hours after death with the Maryland ital Hygiene dother than "natural", or items 23s or 28e-f show avant, its Marice Examination of the modified at	e Co	17. Father's Name (First, Middle, Last)	5+Te.	acher 18. Mother's Nan	ne (First, Middle, Maid		.1
id be ental ked o	To Be	Norman W. Medlar		Made	line Johnso	on	
2 should be filed with and Mental Hygiene is marked other thar aumatic avant, I'e	-	19a. Informant's Name/Relationship (Type	pe, Print) 19b. Maili	ng Address (Street and Number or Ru			Code)
and 2 ealth a n 27 is		Margaret Medlar (Pine Forest Dr.,			
) - x a =		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □R	emoval from State 20b. Place of Dispresentation commetery, cre	osition (Name of matory or other place)	Date 20c.	Location - City or T	own, State
Pages tment of tant: If it		' 4 ☐ Donation 5 ☐ Other (Specify)	Gardens	of the Pines 8/30		erlin, MD	
permit. Departi		21. Signature of Funeral Service License	1 41		he Burbage		Home
		22a. Part1. Enter the disease or compli	cations that caused the death. Do not en	108 William St., ter the mode of dying, such as cardiac		21011	Approximate Interval Between
Physician		Immediate Cause (Final					Onset and Death
/Medical		disease or condition resulting in death)	Due to (or as a consequence of):	Arten D.	ر در در		
Examiner		Sequentially list conditions.)				
sit s	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				
xecut and	xan	that initiated events resulting in death) Last	Due to (or as a consequence of):				
icate be executed physician and sthe burial-transit	dical E						
tificati ng phy as the	ledi						
The law requires that the death certific the law requires that the death certific at has been signed by the attending page 2 should be detached for use as	Physician/Me	23b. was decedent pregnant		□Ectopic pregnancy		23d. Date of deliv	ery Day Year
e dea the at	sici	in the past 12 months? 1 □ Yes 2. No 9 □ Unknown	4☐Pregnant at time of death 5 9☐Unknown	Other (specify)			
that the			ntributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
requires een signe hould be	d by	1.1			1 🗌 Yes	2 No 3 Pro	bably 4 Unknown
w req	Completed				24a. Was an	24b. Were aut	opsy findings available ompletion of cause of
aician: The law s certificate has b lirector, page 2 s	mo mb				autopsy performed	? death?	
ician: T	BeC	25. Was case referred to medical examiner?			ath (Check only one)		
ding Phyaician: The n. After this certificate hr funeral director, page	10	1 ☐ Yes 2 ☐ No	fospital: 1 Inpatient 2 ER/Outpatie		lome 5 Residence		fy)
nding P ath. r: After I	on:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in	прину осситеа	
Attanding Physician: or death. actor: After this certification of the funeral director.	ertification;	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, s		28f. Location (Street		al Route Number,
after Dira	erti	4 Homicide	building, etc. (Specify)		City or Town, St	ate)	
To tha Hospitel or Attandi within 24 hours after death. To tha Funarel Diractor: A completely filled in by the t	edical C	(Check only 2 Medicel Exemi	sicien: To the best of my knowledge, dea ner: On the basis of examination and/or i	ith occurred at the time, date and place nvestigation, in my opinion, death occurred to the contract of the co	e, and due to the cause urred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
To tha within 2 To tha complet	Med	29b. Signature and title of contifier	and manner stated.	29c. License number	29d.	Date signed (Month	, Day, Year)
F X F S		1		D.00548	79 0	X/27	12006
		30. Name and address of person who co	ompleted cause of death (Item 23a) (Type	p, Print)		7	
DZJ 10+	1		314 Franklin Ave.,	Berlin, MD 21811			
		31. Date filed (Month, Day, Year)	32. Registrar's Signature				

			1 - For State Registrar	State of	Marylan		artmen rtificat				lental Hy	giene 2 () Reg. No.	06	29310
			Decedent's Name (First, Middle, La	ist)				-			2. Date of Dea		Year	3. Time of Death
	Physici /Medi		Clarence Do	uglas	Mess	ick					aug		2006	12:35AM
	Examir		4a. Fecility Name (If not institution, gi	e street and num	nber)		,.		Location			4c. County		70
			SATISBURY REHAB		7. Age (In yrs.		SA If Under		URY,	MD •	21804		COMIC	lace (State or Foreign
E	Funeral Director	1	5. Social Security Number 6. 214-30-8916	Sex 12 M 2□F	7. Age (iii yis.	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da Feb. 20	1936	Cour	land
			Usual Residence of Decedent								100.20	1330		
	r 28e-f show		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation						1	0d. Inside City Limits
	Be-1 s	cto	Maryland Wicon	nico		Sal	isbu							1 ☐ Yes 🏋 No
, n.	吉 市 湯	Dire	10e. Street and Number	_ ,			10f. Zip		. 1			10g. Citizen of		ntry?
1	death w	erai	1000 Powhatta:			.S. 13.		218(tent of H		rigin? (Sp	ecify Yes or No	U.S.	A Americ	an Indian,
3.		Funeral Director	1 Never Married Married	1 X Yes	dent Ever in U rces? 2 🔲 No						ecify Yes or No Rican, etc.)		ck, White,	etc.
. 200		by	3 Widowed 4 Divorced	If Yes, Giv Year or Da		3	1 🗆 Yes	21 2 No	Specify	/:		Specii	Bla	ıck
35	72	Completed	15. Decedent's E (Specify only highest g	ducation ade completed)		16a. Dece (Give	dent's Usua kind of wo DO NOT us	al Occup rk done d	ation during mo	st of work	ing	16b. Kind of B	usiness/In	dustry
22	within ane. Ihan	ld m	Elementary/Secondary (0-12)	College (1	-4or 5+)	1	eache		3)			Non	10	
Q 2	Hygi ther int, I	ပို	17. Father's Name (First, Middle, Las				-aciic		18. Moth	ner's Nam	e (First, Middle,			
<u>a</u> <u>E</u>	0 0 0 0	To Be	Theopolus Mess	sick					1	Hele	n Just	ice		
Mary	S DEE	-	19a. Informant's Name/Relationship			19b. Maili	ng Address	(Street			al Route Numbe		State, Zip	Code)
	and 2 salth a n 27 ls		Lynnette Messi	ck (Wif						Blvc	l.Salis			
a Collimore,	000-		20a. Method of Disposition ✓ Burial 2 ☐ Cremation 3	Removal from 5	20b. F	Place of Dispo cemetery, crei	osition (Nar matory or c	ne of ther plac	:е)		9/2/	20c. Location	- City or To	own, State
). <u>E</u>	Pages ment of tant: If It jury or o		Burial 2 Cremation 3		Sp	ringh					1706	Hebro	on, Mo	i.
	permit. Page Department Important: I any Injury o		21. Signature of Funeral Service Lice	20.00		Š	z. Name ar Cewa:	rt I	ss of Faci une	ral,	Home			
				a Stow							Sbury,		301	Approximate
			23a. Part1. Enter the sease, or cor shock, or heart filure. List ont Immediate Cause (Final	one cause	ach line.	1	1				,	,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	aDue.to	or s a conseq	uence of	for	1			/	1	- /	years
18.	Examiner			Chr	me	often	fine	10	ci	ne	former	, Do	val.	12000
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	quence of):		/_	2	-	101	1	•	/
	be executed icien and burial-transit	Exami	Cause (Disease or injury that initiated events resulting in death) Last	c. 0	or as a conseq	x les	el.	1.10	er V		/all t	ex		yell-
8760,	ate be execut hysicien and the burial-trar	E E	Todaling in double, Education	Due to (or as a conseq	(uerice or).								
287	ate phys	dicai		d										
9 X	Attending Physician: The law requires that the death certific in death. sctor: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregna							23d. Da	ate of delive	ery
Вох	death a atter	cial	in the past 12 months?	4□Pregn	irth 2 ☐ Feta ant at time of c		□Ectopic p □ Other (sp		/			М	onth	Day Year
O.	it the de by the a tached	hys	9 Unknown	9□ Unkno	own									
Division of Vital Records, P.O.	es tha igned be del	by P	Part II. Other significant conditions	contributing to de	eath but not res	sulting in the u	inderlying o	ause giv	en in Part	t I.		_	-	he cause of death?
ğ	w require been si	bet									10	res 2 No	3 Prob	pebly 4 □Unknown
ပိ	elawr hasbe je 2sh	Completed									24a. Was autoj	OSY	prior to co	ppsy findings available impletion of cause of
<u>~</u>	The cate has page	ပ္ပြ									1 Yes	rmed? 2 ☑ No	death? 1 ☐ Yes	2 No
Vita	sician: Th certificate irector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Oth			h (Check only o		-	
o to	Physical direction	10	1 Yes 2 No	101		28b. Time o			4 (25)	Tursing Ho	ome 5 Resi			(y)
o	ding I h. After funer	tion	1 Matural 5 Pending 2 Accident investigati		of Injury th, Day Year)	Injury	м	28c. Injur Wor	rk? Yes 2[□No				
İSİ	I or Attendi after death. Director: A I in by the fu	fica	3 Suicide 6 Could not	be 28e. Place	of Injury - At h	ome, farm, st	reet, factor	y, office	-				ber or Rura	al Route Number,
ار م	<u>a</u>	Certification:	4 Homicide determine	buildi	ng, etc. (<i>Speci</i>	Ty)					City or To	wn, State)		
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical ((Check only 2 Medical Ex	hysician: To the	asis of examina									
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and mani	ner stated.		29	c. Licens	e number	r		29d. Date sign	ed (Month,	Day, Year)
	00 0		· MAN	11/				0	25	30	9	87-8	77	-
	261		30. Name and address of person wh	completed caus	se of death (Itee	m 23a) (Type	, Print)		0/1			1 21/	6	
	1011.		WILLIAM ROBINS,					BURY	У, МГ). 2	1804	/		
		ate	31. Date filed (Month, Day, Year)		gistrar's Sign				.,	-				
-	Regist	rar	AUG 3 n	/IIIIh M	0.0	Nº A	Tana att	A						

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 29311

		l- For State Registrar		Cert	ificate of	Death			Reg	g. No	00	0 2331
Physicia ledical Examir	in/ ner	Decedent's Name (First, Midd	Leatha	Pensi	_			5	Date of Death Month September	Day Year 6, 2006	r	3. Time of Death 1651 hrs
		4a Facility Name (if not institution Johns Hopkins Hospi			4	b. City, Town Baltimore	or Location o				imor	e City
Funeral Director	ĺ	5. Social Security Number 470–44–6285	6. Sex 7. Ag	e (In yrs. las	st birthday) Yrs.	If Under 1 Months	Year If Unde Days Hours		9/11/	1938	9 Birth Foreign Cour	Donna
nd thow any		Usual Residence of Decedent 10a. State 10b. County Penna. Fran	nklin		Town or Location							10d Inside City Limits 1 X Yes 2 No
th the Maryland 23a or 28a-f show notified at once.	Director	10e Street and Number 156 South Ca:	rlisle St.	l		10f. Zip Coo			10	g Citizen of Wh	at Count	ry?
death wi	by Fune	11. Marital Status 1 Never Married 2 X N 3 Widowed 4 Di 15. Decedent's Education (Sp	1 Yes 2 ivorced If Yes, Give Year or Dates.	? X No	1 1 16a. Decedent	es, specify Cu Yes 2 X		, Puerto Ric	can, etc.)	14. Race White Specify 16b. Kind of Bus	e, etc. Whi	
136 thin 72 hou ne than "nat edical Exa	Completed	Elementary/Secondary (0-12				an Off	life. DO NOT	use retired)	Bank	ing	
ore, MD 21215-0036 ss I and 2 should be fifted within 7 of Health and Mental Hygiene If item 27 is marked other than her tranmatic event, the Medica	Be	17 Father's Name (First, Middle $Dwight\ G.$	Elliott				V	ida Ba	arnhart			
MD 21 od 2 should alth and Me m 27 is ma aumatic ex	2	19a. Informant's Name/Relation Thomas R. Per			156 \$	South	Carli <u>s</u> l	le St.	. Green	ber, City or Town	Pa.	17225
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after Department of Health and Meutal Hygene Important: If item 27 is marked other than "natural". injury or other tranmatic event, the Medical Examiner		20a Method of Disposition 1 X Burial 2 Crematic 4 Donation 5 Other 5	Specify:	tate cr	lace of Disposi rematory or oth ar Hill	erplace) L Ceme	tery	9/11		Greence	ast1	e Pa.
Balt permit Depart Impor injury		21 Signature of Funeral Service Martin	Licensee Limber complications that caused	_50	~ , 45	5 Sout		isle S	St. Gre	encast1	e Pa	neral Home 1. 17225 Approximate Interval
Physician //wedical Examiner		23a Part I Enter the disease, of failure. List only one caus Immediate Cause (Final diseas or condition resulting in death)	e on each line. se a Hypotensi o	on and s	su ^t sequer						art .	Between Onset and Death
Mary Mills	<u>.</u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons b. Tracheal :	injury								
l it	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence of)).			trache	ostomy i	rocedure		
760, icate be executed physician and the burial - transit		X UNPENDED	Recurrent AMENDED #2		ary thyro 7, 28a-f.			11/21/0	6 TT	-		
68 certif		IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 U	the 23c If yes, outcome the 1 Live birth	me of pregn	ancy 2 Fet					23d Date of Month	delivery Da	ay Year
P.O. B es that the d gned by the	by Phy	Part II. Other significant cond		th but not re	sulting in the u	nderlying cau	ise given in Pa	art I.				ne cause of death?
cords, law require has been si	Completed								24a Was a autops perform	med? c		opsy findings available impletion of cause of s 2 No
Vital Recysician: The his certificate director, page	Be	25. Was case referred to medic examiner?	Descript				Other4				1.	
FVij Physic er this ral dir	ဥ	1 ✓ Yes 2 No 27. Manner of Death	1 Inpat		ER/Outpatient 28b. Time of Ir		Injury at Work	Nursing F		Residence 6	Other:	
n of viding Ph	ion:	1 1	(Month, Day)	Year)	2:22 pm		Yes 2	1 No.		, ,		
Divisior pital or Attend ours after death neral Director: filled in by the	Certification:	2 X Accident Inv	vestigation 28e. Place of l		ome, farm, street ve suite			tc 28			er or Rur	al Route Number, City coadway
To the Hosp within 24 hos To the Fune completely fi	Medical C	29a Certifier 1 Certifying	Physician: To the best of r xaminer:On the basis of ex and manner stated	amination ar	ge, death occur nd/or investigat	red at the timition, in my op	e, date and plainion, death or	ace, and du	ue to the caus the time, date a	e(s) and manner and place, and d	r as starte due to the	ed cause(s)
E % E 8	Me	29b Signature and title of certification of the Signature and title of certification of the Signature and title of certification of the Signature and title of certification of the Signature and title of certification of the Signature and title of certification of the Signature and title of certification of the Signature and title of certification of the Signature and title of certification of the Signature and title of certification of the Signature and title of certification of the Signature and title of certification of the Signature and title of certification of the Signature and	King In.	m	0		.C.M.E.			29d. Date sign September		-
		30 Name and address of personal Theodore M. King, J	r., MD. Assistant I	Medical E	xaminer		Street, Ba	altimore,	MD 21201			
S Regis	tate trar		2006 Registi	ar's Signatu	1004	20						

06-06615 Claudia Aguado

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Rea. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Claudia Aguado Physician/ 0900 hrs September 4, 2006 **Medical Examiner** 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Raltimore 128 West Franklin Street #518 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number **Funeral** Foreign Nicaragua Country) Months Days Hours Director October 21,1954 None 51 M 2 XF Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location Ĭ State 10b Count 1 Yes 2 X No 28a-f show Maryland Montgomery Kensington permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shi injury or other traumatic event, the Medical Examiner must be notified at once rector 10f. Zip Code 10e. Street and Numbe 10g Citizen of What Country 20895 10811 Hobson Street Nicaragua Ö Funeral 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, Black White, etc. Armed Forces? 1 X Never Married 2 Married 2 X No Yes 1 Yes 2 No specify: Nicaraguan White f Yes, Give Year Specify. Widowed Divorced \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12 Elder Care Health Care 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carlos Aguado Dora Padilla 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10811 Hobson Street, Kensington, Maryland 20895 Dora Aguado/ Mother 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) September 1 X Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 2006 Silver Spring, Maryland Donation 5 Other Specify 22 Name and Address of Facility. Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, 21. Signature of Funeral Service Licenses MD 20901 . Ken 5 Killes 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death Hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immedia Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and sician/Medical X UNPENDED AMENDED attending physician or use as the burial item#1,23a,27,perME,g859,9/28/06 TT that the death certificate be Division of Vital Records, P.O. Box 68760 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year use as 1 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 ✔ Unknown Linknown gned by the a detached fo 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. signed by ₫ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy After this certificate has death? page 2 performed ✔ Yes 2 1 🗸 26 Place of Death (Check only one) 25 Was case referred to medical Be Other₄ Hospital: 1 examiner? Inpatient ER/Outpatient 3 DOA Nursing Home 5 Residence 6 🗸 Other: Scene 2 1 🗸 Yes 2 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day,Year 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 X Natural Yes 2 No 5 Pending after death within 24 hours after death To the Funeral Director: the 2 Accident Investigation in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) mo O.C.M.E. September 5, 2006 h 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ling Li, MD Registrar's Signature 31. Date filed (North Pay, Year) State FOR SHE Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended #8, nls, 09/06/06, Allegany County State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) SEPTEMBER **Physician** 4, 2006 РМ MARIE ELIZABETH PORTER 1:15 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ST VINCENT de PAUL NURSING CENTER ALLEGANY FROSTBURG If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (North Day) 10-03-190 9. Birthplace (State or Foreign **Funeral** Maryland 1 M 2 N F 213-01-5455 100 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State Item 27 le marked other than "natural", or Iteme 23a or 28a-f ehow other traumatic event, the Mudical Examinar must be notified at Frostburg 1 ¥ Yes 2 ☐ No Maryland Allegany Director 10e. Street and Number 108 Center Street 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be tiled within 72 hours after death with nent of Health and Mental Hygiene. Int: If Item 27 le marked other than "natural", or Iteme 23a or: U.S.A. 21532-Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clothing Manufacturer Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be le marked o Gertrude Steele John Kamauf 2 19a. Informant's Name/Relationship (Type, Print)
Wayne Gray 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 106 McKinley Ave. Cumberland Maryland 21502 grandson f Health 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Frostburg Memorial Park 07-Sep-2006 Frostburg Maryland permit. Page Department of Important: If any injury or ance. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 ohn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, whock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dementi Advunced 2 years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duarto (or as a consequence of) Examine or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Month 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown certificate has been si rector, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 1 ☐ Yes 2 X No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 | Inpatient Other: 1 Yes 2 No ၉ 2 ER/Outpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 1 KNatural 2 ☐ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hours after death

To the Funerel Director:
completely filled in by the Hospital ۽

> WONSOCK 31. Date filed (Month, Day, Year) SEP 0 5 2006 State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHIN MD 48 Turn Tenuce

MD

29c. License number

Frostburg MD 21532

29d. Date signed (Month, Day, Year)

Sep 05, 2006

worsocksten 06055325

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink

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Harold Samuel Ro		S - For State	tate of		and / D	epar	tment of	Healt	h and		tal Hy	giene		20	2.0	2021
	F	Registrar	llo I oot\			Ceru	ificate of	Deau				Re 2. Date of Deatl	g. No.	20	3. Time	of Death
Physiciar Medical Examin	۳.	1. Decedent's Name (First, Mide Harold Samuel		s							ľ	Month August 25	Day 2006	Year		9 hrs
y grander		4a. Facility Name (if not instituti	on, give st	reet and nu	ımber)		4	b. City, T Bethe		Location of			4c. Cou	nty of Deal	h	
Euperal		Suburban Hospital 5. Social Security Number	6. Sex		7. Age (In	yrs. las	st birthday)		er 1 Year	If Unde	er 24Hrs.	8. Date of Birt		YYYY 9 B	rthplace (State or
Funeral Director	١	217-44-7831		2 F		52	Yrs.	Month	s Days	Hours	Min.	March	24, 19	Fore C	grWash ountry)	ington, D.C.
		Usual Residence of Decedent			Lo	01. 7									10d los	ide City Limits
ow any		10a. State 10b. County			100	c. City, I	own or Location									res 2 XNo
aryland 3a-f sh		Maryland Mon 10e. Street and Number	tqome	ry			Germa	10f. Zip				10	g. Citizen o	f What Co	intry?	
the M. a or 22		19222 Crystal	Rock	Driv	e					2	0874			USA		
t be no	Funeral	11. Marital Status 1 Never Married 2		2. Was Dec		er in U.S						cify Yes or No- Rican, etc.)		Race - Ame Vhite, etc.	rican India	ın, 8lack,
er dear		3 Widowed 4 x D	vorced If	Yes, Give Yea	2 er 1964	No 4-70	1	Yes 2	₃r No	specify:			Spec	cify: W	hite	
ours aft ntural	홝	15. Decedent's Education (Sp	- 0	Dates.			16a. Decedent	's Usual	Occupat	ion (Give	kind of wo		16b. Kind o			
6 n 72 hc an "n: ical E3	Completed	Elementary/Secondary (0-12)	College (1	1-4 or 5+)		Ü					(d)		nicatio		
5-0036 led within 7 Hygiene other than	Ē	17. Father's Name (First, Middl	e, Last)	3			Sy	stem		gine		First, Middle, N		nolog ame)	<u> </u>	
215. be filed ntal Hy rked of	B B	George Marcu		1s							Beti	y Luci	lle Pi	ritch	ard	
		19a. Informant's Name/Relation Damon Alexis				i			,			ural Route Num Edgew				le)
mad 2 s ealth a sem 27 traum	1	20a. Method of Disposition	KOIIS	7 5011	· 		lace of Disposi	tion (Nar	ne of cer			Date Just 29		tion - City o		tate
Baltimore, Bartimore, Permit. Pages La Departament of He Important: If it		1 Burial 2 Crematic		Removal fr	rom State		rematory or oth			ator	1	2006	Alexa	andri	a, Vi	rginia.
Partin portan	1	Donation 5 Other Signature of Funeral Service		•	1		22. N	ame and	Address	of Eacilit	l lins	Funera	1 Home	e Inc		
		23a. Part I Enter the disease,	D.	Ly		1 11 - 1	50	O Un	iver	sity	B1v	d, W, S	ilver	Spri	ng, N	ID 20901 ximate Interval
Physician /Medical Examiner		failure. List only one caus Immediate Cause (Final diseas or condition resulting in death)	e on each se a. Hy	line.	ve Athe	roscle	erotic Cardi				Sal Glac of	respiratory arre	Jan Shook, o	Trout (een Onset and Death
1 - Act.		Sequentially list conditions,	b												_	
	jug.	if any, leading to immediate cause. Enter Underlying Caus (Disease or injury that initiated	е	e to (or as a	a consequ	ence of)									1	
ed	Examiner	events resulting in death) Las		e to (or as a	a consequ	ence of)):									
execul an and al - tra	dical	UNPENDED	a	AMENDED							<u> </u>					
760, cate be physici he buri	Med	IF FEMALE:		23c. If yes,	outcome o	of pregn	ancy						23d. Da	te of delive	ry	
: 68760 certificate b ending physi- use as the bu	sician/Me	23b. Was decedent pregnant in past 12 months?		1 Live I	birth nant at tim	e of dea		al death ner (Spe		Ectopi	ic pregnar	icy	Mon	ith	Day	Year
Box e death c the atten	hysi	1 Yes 2 No 9 U	mlum muum	9 Unkn	nown		0	iei (opo	,							
P.O. es that the igned by be detach	by P	Part II. Other significant cond	litions co	ontributing t	to death bu	ut not re	sulting in the u	nderlyin	g cause (given in P	art I		bacco use o			e of death? Unknown
of Vital Records, ng Physician: The law required the this certificate has been someral director, page 2 should	Completed											24a. Was autop	sy	prior to	completio	dings available on of cause of
Recc The lav	mo		-									perfor 1 ✓ Yes	med? 2 No	death?		2 No
cian: certifi	Be	25. Was case referred to medi examiner?		spital:			ER/Outpatient	2 7	26.Place	of Death Other		nly one)	Daaidanaa	e d Oub	ar Casas	
n of Vit ding Physic After this	<u>.</u>	1 Yes 2 No 27. Manner of Death		28a. Date	Inpatient e of Injury	$\overline{}$	28b. Time of I			ry at Worl		28d Describe I			er. Scene	
ision (Attending or death rector: Af	tion		nding restigation		ih, Day,Year))			1	Yes 2	No					
Division In or Attendi rs after death al Director:	Certification:	3 Suicide 6 Co	uld not be	28e. Pla		y - At ho	me, farm, stree	et, factor	y, office I	ouilding, e	etc.	28f. Location (S or Town, S		lumber or F	Rural Rout	e Number, City
Divi Hospital or . 24 hours after Funeral Dir tely filled in		4 Homicide	termined	(Specify			- dooth coor	rod at th	a tima d	ate and al	lace and	due to the caus	o(s) and mo	nnor oc et		_
To the How within 24 k. To the Fu	Medical	(Check only one) 1 Certifying certifying 2 ✓ Medical E	xaminer:0	n the basis	of examin	nowledg nation ar	nd/or investiga	ion, in m	y opinior	n, death o	ccurred a	due to the caus the time, date	and place, a	and due to	the cause	(s)
_ 5+1	Me	29b. Signature and title of cert		nd manner	stateu.	-2	-	29		se number	r			signed (N		Year)
311		Caro	6	110	Cl	L	Lau		O.C.	M.E.			August	26, 200	6	
		30. Name and address of pers Carol Allan, MD		mpleted cau			^{23a)} 111 Penn :	Street	Baltim	ore, MI	D 2120					
St	ate			200	Registrar's			9 9		,						
Regist		101111111111111111111111111111111111111	2008	I LIA	BINC	10.	SA JUST	hard								

		-	For State Registrar	State of Marylan		irtment of tificate		Mental Hygie Reg.	ne no.2006	29316
			1. Decedent's Name (First, Middle, Last)					2. Date of Death	Day Year	3. Time of Death
	Physicia		Althea	Mae		Ranck		SEPTEMBEI		1000 A M
)	/Medio Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Tow	n, or Location of Death		4c. County of Death	
	Zxami		MEMORIAL HOSPI	ΓAL		CUMBER	LAND		ALLEGANY	
	Funeral		Social Security Number 6. Sex		last birthday)	If Under 1 Ye		8. Date of Birth (Month, Day, Ye	9. Birth	nplace (State or Foreign untry)
	Director		215-26-7176	м 21XF 77	Yrs.	WOTHING Da	y3 110013 Will.	04/20/19	-	yland
	p ,	-	Usual Residence of Decedent 10a, State 10b, County	10c Cit	v. Town or Lo	antion				10d. Inside City Limits
	aryla ehov	-								1 Y Yes 2 □ No
	8a-f	Director	MD Allega	ny	Cumbe			10	077	
	vith ti		10e. Street and Number 106 N. Allegany	Street		10f. Zip Cod	° 21502	10g.	Citizen of What Co	untry?
	s 23s	Funeral		2. Was Decedent Ever in U.	C 12 V	Man Donadont	of Hispanic Origin? (S	pacify Vac or No-	14. Race - Ame	rican Indian
	ltem Item	nu.	11. Marital Status 1 ☑ Never Married 2 ☐ Married	Armed Forces?	.s. 13. V	Yes, specify C	cuban, Mexican, Puert	o Rican, etc.)	Black, White	
36	rs aft	by F	3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	I∐Yes 2¶∏	No Specify:		Specify:	hita
2-0036	tura eal E	ed ed	15. Decedent's Educ		16a. Deced	lent's Usual Oc	cupation	16b	. Kind of Business/l	hite Industry
212	n n	Completed	(Specify only highest grade	completed) College (1-4or 5+)	(Give	kind of work do DO NOT use re	ne during most of wor tired)	king		
2	d with	E O	12	3	Nu	rse			Nursing	Home
פ	othy oth	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle, Maid	den Sumame)	
Maryland 2121	should be filed within 72 hours after death with the Maryland of Mental Hygiene. The Mental Hygiene. The Medical from "netural", or litems 23a or 28a-f ahow marked other then "netural", or litems 23a or 28a-f ahow maric event, the Medical Exercine mast be notified at	70	Clifford	Vaughn	Ran	ck	Leona	Mae Mae	Cr	aze
a	2 should and Men le marke sumatic		19a. Informant's Name/Relationship (Type	oe, <i>Print)</i>	19b. Mailin	g Address (Str	eet and Number or Ru	ıral Route Number, Ci	ity or Town, State, Z	(ip Code)
	s 1 and 2 should of Heelth and Men item 27 le marke other traumatic		Ronald Emerick / no					mberland,		
altimore,	of Hori		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	Place of Dispo cemetery, cren	sition (Name o natory or other	place)	Date 200	. Location - City or	Town, State
Ē	Pages ment of ant: If its ury or o		4 Donation 5 Other (Specify)	Cur			atory 09/0		umberland	,
	permit. Pages Depertment of Important: If it eny Injury or o		21. Signatura of Funeral Service License	90				-		Home, P.A.
<u> </u>	20 E 2 9		Malut C. H	lu-2				t, Cumberl		21502
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the deat e cause on each line.	h. Do not ent	er the mode of	dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Chrisic	Obsta	uctive	Culmo	rany Dis	leare	SYVI
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):			σ		,
I	Examinor	_	Sequentially list conditions,	Due to (or as a conseq	uance of):					
	ed sit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dao 10 (0. 43 4 001304	dones or,.					
•	xecu and al-trai	Examiner	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):					
8760	The law requires that the death certificate be executed sie has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dical E								
68	ificate p phy as the									
	nding use a	Z	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta		75-4			23d. Date of deli	ivery
P.O. Box	that the death certifined by the attending poderached for use as	by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐ Pregnant at time of c		Ectopic pregna Other <i>(specif</i>)			Month	Day Year
Ö	tt the by th tache	hys	9 Unknown	9□ Unknown						
	res tha igned be del	Ž.	Part II. Other significant conditions con	tributing to death but not res	utting in the u	nderlying cause	given in Part I.		_	the cause of death?
D C	w requir been si should I							112 Yes	2 □ No 3 □ Pr	obably 4 Unknown
၁	has be	Completed						24a. Was an autopsy	prior to d	topsy findings available completion of cause of
<u> </u>		5						performed 1 ☐ Yes 2 ≥	d? death? DNo 1 ☐ Yes	2 🗆 No
ita	ysician: The is certificete director, pag	Be (25. Was case referred to medical examiner?				_	ath (Check only one)		
<u>></u>		ဥ	1 □ Yes 2 No		ER/Outpatien			lome 5 Residence		eify)
ב	Attending Physician: r death. ector: After this certific by the funeral director.	Ë	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		njury at Work?	28d. Describe how	injury occurred	
sio	tand leath tor: /	cat	2 Accident investigation 3 Suicide 6 Could not be				1 ☐ Yes 2 ☐ No	004 1 (04		15
Division of Vital Records,	or At fter c pirect in by	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Special		eet, factory, off	ice	28f. Location (Stree City or Town, S		irai Houle Number,
ب	pital burs a sral [29a. Certifier + Certifying Physical Certification Certi	sician: To the best of my kno	nwledge dest	n occurred at th	e time, date and place	and due to the source	a(c) and manner as	ctated
	To the Hospital or Attending Phys within 24 hours after death. To the Funsral Director: After this completely filled in by the funeral di	Medical	(Check only 2 Medical Examinations)	ner: On the basis of examination and manner stated.	ation and/or in	vestigation, in r	ny opinion, death occu	urred at the time, date	and place, and due	to the cause(s)
	o the	Me	29b. Signature and title of certifier			29c. Lio	ense number	29d.	Date signed (Monti	h, Day, Year)
	- > - 5		D H _ 1			D	0033282	SEP	TEMBER G	2006
•	,		30. Name and address of person who co	impleted cause of death (Iter	m 23a) (Type,					
	Thas						ue, Cumber	land, MD	21502	
	Sta		Sunil K. G 31. Date filed (Month, Day, Year) SEP 0 5 200	32 Registrar's Signa	ature	antis.				
	Regist	ar	SEL O O FOOT	1180 A	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	-64				

			For State Registrar			/land / De		nt of H	lealth a	and N	Mental Hygie	ene	006.	29317
			Decedent's Name (First, Midd.	e, Last)							2. Date of Death			3. Time of Death
	Physicia /Medic		Clinis	Slı	ıss						Month 08	27	Year 06	7:12p M
	Examin		4a. Facility Name (If not institution	n, give street an	d number)		4b. City	Town, or	Location of	of Death		4c. Cour	nty of Death	
			CIVISTA MED					LATA				CHAR		
	Funeral Director		5. Social Security Number 213-46-8377	6. Sex 1 M 2/X		n yrs. last birthd Yrs	Months		If Under Hours	Min.	8. Date of Birth (Month, Day May 28,1	936	9. Birthpl Coun Virg	lace (State or Foreign try) inia
	and		Usual Residence of Decedent 10a. State 10b. County		10	c. City, Town o	Location						10	0d. Inside City Limits
	Maryl -f ehc	Į.	Maryland Cha	rles		Nanj	emoy							1 ☐ Yes 2 No
	r 28a	Director	10e. Street and Number					Code			100	g. Citizen d	of What Coun	try?
	th with		8425 Bowie R	oad				20	662			U.S	.A.	
	dea dea	Iner	11. Marital Status	Ame	Decedent Eve	r in U.S.	3. Was Dece If Yes, spe	dent of H	ispanic Ori	igin? (Sr	pecify Yes or No- Rican, etc.)		ace - Americ	
215-0036	permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Madical Exalliner mat be multified at since.	Completed by Funeral	1 ☐ Never Married 2 🔀 Mar 3 ☐ Widowed 4 ☐ Divorced	ned 1 🗀 1 If Year	es 2 XNo s, Give or Dates:				Specify:			Spec	eity: Whi	te
5.5	72 h natu	etec	15. Deceder (Specify only highe	nt's Education est grade comple	ted)	16a. De	icedent's Usu ive kind of wo e. DO NOT u	al Occup	ation during mos	st of worl	king	6b. Kind of	Business/ind	dustry
	within sne. then	dm	Elementary/Secondary (0-12)	Colle	ge (1-4or 5+)				"			Her	Home	
/ د ط 21	Hygie ther ther		6 17. Father's Name (First, Middle,	Last)		п	omemak	er	18. Mothe	er's Nam	ne (First, Middle, Ma			
a N	d be ental ked o	To Be	Roosevelt		lins				М	laggi	ie Collin	ns		
S S'	should Mark	-	19a. Informant's Name/Relation:			19b. M	ailing Addres	s (Street			ral Route Number, (m, State, Zip	Code)
	alth a 27 is		Rex R. Slus	s Hu	sband	842	5 Bowi	e Ro	ad, N	Janje	emoy, Md.	2066	2	
i.	of Heart Item		20a. Method of Disposition	o [] o	2	20b. Place of Di	sposition (Na crematory or	me of other plac	(a)Cont	. 1	Date 20	Oc. Location	n - City or To	wn, State
	Page nent c ant: If		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (\$	3 ⊟Hemova⊓ Specify)	rom State	Pisgah	Nazare	ne C	hurch	î Cer	netery P:	isgah	, MAry	land
Cハカ Baltimore,	Deparit Deparit Import Import Info		21. Signature of Funeral Service	Licensee			22. Name a	nd Addre	ss of Facili	ity Ho	ome, P.A.			
- 00	805 2 3		miles	llion	\rightarrow M	100668	4270 H	$\Delta w + h$	orne	Rd.	Indian	Head,	Md. 2	0640
	3		23a. Part1. Enter the dishase, o shock, or healt failure. Lis	r complications t t only one cause	half used the on each line.	death. Do not	enter the mo	de of dyin	g, such as	cardiac	or respiratory arres	st,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (inal disease or condition resulting in death)	_ a f.	new	more								511051 2110 25241
	/Medical Examiner		resulting in death)	Du	e to (or as a co	onsequence of):	1							
5		-	Sequentially list conditions,	b	e to for an a re	onnecuanga obi	Mys	in	سئي~	-			-	
	uted insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<	lua a	ritt	< 30	21-	her					
ć	be executed sician and burial-transit	Exa	that initiated events resulting in death) Last	C. Du	e to (or saco	onsequence of):				1				
760,	sicia bur	cal		d	coro	nany	ast	czy	de	2	rse			
68	tifical ng ph	Medi	AR CELLAL E			0		ŀ				1		
.O. Box 68	The law requires that the death certificate to has been signed by the attending phy age 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 🗀 L 4 🗆 F	s, outcome of p live birth 2 E Pregnant at time Inknown	Fetal death	3 Ectopic p 5 Other (s						Date of delive Month	Day Year
0	res that igned b be deta		Part II. Other significant condit	ons_contributing	to death but n	ot resulting in th	e underlying	cause giv	en in Part I	I.	23e. Did toba	cco use co	ontribute to th	ne cause of death?
rds	w require been sig should b	edt	Syperlene	in, 1	type	lipede	me	ohe	trus	tu	1 Yes	2 🗆 No	3 🗌 Prob	ably 4 🗀 Unknown
Division of Vital Records, P.O	The law requate has been page 2 shoul	Completed by	sleep aps	ea, it	story	myor	andi	ندي	rfai	stry	24a. Was an autopsy performs	ed?	b. Were autop prior to cor death? 1 🔲 Yes	psy findings available appletion of cause of
ital		BeC	25. Was case referred to medical	ıl	77 - 13 - 14				26. Place	e of Dea	th Check only one		1 103	20110
>	nysici	To	examiner? 1 🗌 Yes 2 🐔 No	Hospital:	1 Inpatient	2 ER/Outpa	tient 3 D	OA Oth	er: 4 □ Nu	ursing H	ome 5 🗆 Residen	се 6 🗆 С	Other (Specify	<i>(</i>)
0 0	iding Physician: th. After this certifical funeral director.		27. Manner of Death 1 ☑Natural 5 ☐ Pendi	28a. I	Date of Injury Month, Day Ye	9ar) 28b. Tim Inju	e of	28c. Injun Wor	y at k?		28d. Describe how	v injury occ	urred	
Sio	tendi eath. tor: A	cati		igation not be			М		Yes 2]No				
Divi	l or Attending Physician: after death. Director: After this certific in by the funeral director.	Certification:	4 Homicide deter	nined 289. I	Place of Injury outlding, etc. (5	- At home, farm Specify)	street, factor	y, office			28f. Location (Stre City or Town,	et and Nui State)	mber or Rura	I Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	Medical C	29a. Certifier 1 ✓ Certifyi (Check only one) 2 ☐ Medica	Examiner: On	o the best of m the basis of ex- manner stated	amination and/o	eath occurred r investigation	at the tin	ne, date ar pinion, dea	nd place ath occu	, and due to the cau rred at the time, dat	use(s) and e and plac	manner as st	ated. the cause(s)
	To the within 2 To the comple	Ž	29b. Signature and title of certific	3r	4		29	c. Licens	e number		290	d. Date sign	ned (Month,	Day, Year)
			Jane	Int the	of from	ND		D-000	08370		Ce	coqu	1 28	20060
(DE		30. Name and address of person	who completed	cause of death	h (Item 23a) (Ty	pe, Print)		29076 8000 1	SAUTE-	Zakrajaka wasa -	1		
4	CUC		PRTTCHETT, 31. Date filed (Month, Day, Year	PAUL E.	MD 118 32. Refistrar's	LAGRAN	GE AVE	AUE 1	A FL	ATA,	MD.20646			
	Sta Registr			3 1 2006	Locus	Signature J	Spense							

			For State Registrar	State of Maryland		tificate of D	eath	Reg. I		
	Physici		1. Decedent's Name (First, Middle, Last) HOWARD LAWR	ENCE STEV	ENS			Date of Death Month ptembe	r 5 2006	3. Time of Death 5:26 PM
)	/Medic Examir		4a. Facility Name (If not institution, give s FREDERICK MEMO		AL	4b. City, Town, or U		1	4c. County of Death	c K
	Funeral Director		5. Social Security Number 6. Security Number 218-18-4222			If Under 1 Year Months Days	If Under 24 Hrs. 8. Hours Min.	Date of Birth Month, Day AUS • 20 •	9. Birthi	place (State or Foreign Tyland
	e Maryland a-f ehow	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Free	derick 10c. City,	Town or Lo	Frederic	ck			10d. Inside City Limits 1 Mayes 2 ☐ No
	h with th	Funeral Director	10e. Street and Number 6351 Spring Ridg	e Parkway, Apt	. 103	10f. Zip Code	21701	10g.	Citizen of What Cou U •	ntry? S.A.
036	be filed within 72 hours after death with the Maryland tal Hygiane. d other than "natural", or itema 23a or 28a-f ehow event, the Madical Examinar must be notified at	ğ	11. Marital Status 1 Never Married 2 Married 3 Nover 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	i	Was Decedent of His f Yes, specify Cuban I □ Yes 2 No	panic Origin? (Specify, Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - Ameri Black, White, Specify: W	
0-CLZ	hin 72 ho en "natur Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)			tion uring most of working		. Kind of Business/Ir	
Z	filed wit Hygiane Sther the	Соп	10 17. Father's Name (First, Middle, Last)	Aį	rport	Owner/Ope			ots train	ing
/lan	a is a	To Be	George B. St	evens			18. Mother's Name (F Lorr			
Mar.	d 2 sth arthur trau		19a. Informant's Name/Relationship (Ty Patricia A. Chipl	pe, Print) ey/Daughter	19b. Mailir 8224	Red Wing	Court, Fr	oute Number, Cit ederick,	ty or Town, State, Zij MD 21702	Code)
Baltimore, Maryland 21215-0036	permit. Pages 1 an Department of Heał Important: If Item 2 eny injury or other <u>once.</u>		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	20b. Pla Removal from State Mt. c	ace of Dispo	sition (Name of name of name of name of name of name of name of name of name of name of name of name of name of	Septemb	er 9, 20c	Location City or T 06 Frede	own, State rick, MD
Balt	Departm Departm Importar eny injui		21. Signal of Funeral Service Licens	My MgC	0021 1	Name and Address eeney and	Basford F	uneral F	Home	21701
	Physician /Medical		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the death.	. Do not ent	O6 East C er the mode of dying	hurch Stre	et, frecespiratory arrest,	ierick, ML	Approximate Interval Between
Æ.			Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ	stive	Heart Fail	ure			Onset and Death
	Examiner	J	Sequentially list conditions,	0						
7	cuted d ansit	Examiner	n any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	ance ory.					
68760,	ificate be executed g physicien and as the burial-transit	al Ex	resulting in death) Last	Due to (or as a consequ	ence of):					
	(2) (d)	Aedical	TE ECHALE.	d						
О. Вох	The law requires that the death certif vie hes been signed by the attending page 2 should be detached for use a	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
Division of Vital Records, P.O.	w requires that been signed by should be deta	ed by Ph	Part II. Other significant conditions co.	ntributing to death but not resu	lting in the u	nderlying cause give	n in Part I.		co use contribute to t 2 ₩No 3 □ Pro	he cause of death? bably 4 Unknown
l Reco	The law re ete hes bee page 2 sho	Completed						24a. Was an autopsy performed 1 ☐ Yes 2 ☑	? death?	opsy findings available impletion of cause of
Vita	ician: certific rector.	Be	25. Was case referred to medical examiner?	Hospital:		othe Othe	26. Place of Death (C			
J Of	ng Physical dispersal di	on; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	1 Minpatient 2 L	ER/Outpatier 28b. Time o Injury	1 3 DON	4 Nursing Home	Describe how in	e 6 □Other (Speci njury occurred	(y)
/isio	To the Hospital or Attending Physicien: The lav within 24 hours after death. To the Funeral Director: After this certificete hes completely filled in by the funeral director, page 2	Certification;	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	me, farm, str	M 1□Y	es 2 No	Location (Street	t and Number or Rur	al Route Number,
á	To the Hospital or A within 24 hours affer To the Funaral Dire completely filled in by		4 Hornicide	building, etc. (Specify			a data and place and	City or Town, Si		
	To the Hospital within 24 hours a To the Funaral completely filled	Medical		sicien: To the best of my knowner: On the basis of examination and manner stated.				at the time, date	and place, and due t	o the cause(s)
	To t within To ti	Ž	29b. Signature and title of certifier	M.D.		29c. License	number 55793	29d.	Date signed (Month,	
	8		30. Name and address of person who co	Menon M.D.	23а) (Туре, Гса	erick Memor	ial Hospital	700 Wes	st Seventh	Street
	St Regist	ate rar	31. Date filed (Month, Day, Year)		ure	Spark		Frederi	ck, MD 21	701
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DHMH 17 Rev 1/2001

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<b>1</b>	Physici	an	1. Decedent's Name (First, Middle, La								Date of De Month	D		ear .	3. Time o	
	/Medic Examir	cal	Maria (NMN) Sulmo:  4a. Facility Name (If not institution, giv		)		4b. City.	Town, or	Location of		eptem		5, 20 c. County of		5:10	P ^M
*	Examili	lei 	Northampton Manor				Fred						ederi			
	Funeral		Social Security Number     6. S		ge (In yrs.	last birthday)			If Under 2 Hours	Min.	Date of Bir (Month, Da	y, Year	7)	Count		or Foreign
45.S	Director	2	Usual Residence of Decedent		70	Yrs.				0	ct. 18	3, 1	935 I	taly		
	yland		10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation							10	d. Inside C	ity Limits
	e Mar	Director	Maryland Frederic	k	Fred	erick	,								1 🗌 Yes	2 <b>X</b> No
	with th	Dire	10e. Street and Number				10f. Zip						itizen of Wha	at Count	ry?	
	within 72 hours after death with the Maryland ene. then "natural", or items 23s or 28s-1 show ha Madical Examiner must be notified at	Completed by Funeral	8299 Elaine Way	12. Was Decedent	Ever in U	.S. 13.	217 Was Deced		spanic Orig	in? (Speci		JSA -	14. Race -	America	n Indian.	
9	after o	Fun	1 ☐ Never Married 2 🔀 Married	Armed Forces 1 □Yes 2 📉	? No					Puerto Ri	fy Yes or No can, etc.)		Black,	White, e		
9	ural',	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 Yes	ZINO	Specify:				Specify:	Whi		
15	n 72 h	lete	15. Decedent's E. (Specify only highest gra			(Give	dent's Usua kind of wor DO NOT us	rk done di	uring most	of working		16b. l	Kind of Busin	ess/Indi	ustry	
212	l withi	ошь	Elementary/Secondary (0-12)  5	College (1-4or	5+)	homem		20 - 01,11 00,				own	home			
힏	al Hyg t othe vent,	BeC	17. Father's Name (First, Middle, Last,						18. Mother	's Name (/	First, Middle,					
yla	Ment Ment Marked Marked	10	Pasquale Mariglia						Anna l							
Maryland 21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If Item 27 Ie marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinat must be natified at ance.		19a. Informant's Name/Relationship (										or Town, Sta			
<b>.</b>	Heal Heal tem 2		Giovanni Sulmonte 20a. Method of Disposition	, musband	20b. F	Place of Disponentery, crei				Dat	ck, Ma		ocation - Cit	2170 y or Tov		
E	Peges ient of nt: If I		1 Surial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		,	. Olive				9/200	06	Fre	derick	. M:	arvla:	nd
Baltimore,	permit. Depertminity imports any inju		21. Signature of Funeral Service Licer	1500									sford			
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8760,	Physician /Medical Examiner  but a properties of the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in the private in th	dicai Examiner	Immediate Causa (Final disease or esudation resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Dement: Due to (or as  b. Due to (or as  c. Due to (or as  d.	s a conseq	uence of):									Onset and	Death
O. Box 6	death certif e attending d for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	Idéath 3[	Ectopic pr	egnancy					23d. Date o Month		-	Year
Vital Records, P.	Se us	by	Part II. Other significant conditions of Hydrocephaly	ontributing to death I	but not res	ulting in the u	nderlying ca	ause give	n in Part I.				use contribu			
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m m	The tate has page	Com	Diabetes Mellitu	S							autop perfo 1 ☐ Yes	rmed? 2 <b>X</b> N	dea	th?	pletion of a 2□ No	ause or
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ð	Physic rthis ral dir	. To	1 ☐ Yes 2 💢 No 27. Manner of Death	Hospital: 1 Inpati		ER/Outpatier 28b. Time o			4 <u>77</u> 114013		5 Resid		6 Other (	Specify)		
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Division of	al or Atters after dear I Director	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of In building, e			eet, factory	, office		28f	Location (S City or Tox		nd Number (	or Rural	Route Num	iber,
	To the Hospital or Attending Physician: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical (	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the best niner: On the basis of and manner s	of examina	wledge, death tion and/or in	h occurred vestigation,	at the time, in my op	e, date and inion, death	place, and occurred	due to the at the time,	cause(s date an	s) and manne nd place, and	r as sta due to t	ted. he cause(s	;)
	within To t	Σ	29b. Signature and title of certifier			(/	290	. License	number			29d. Da	ate signed (A	Aonth, D	ay, Year)	
)	3.1		· Cuyene B.	/asag-	in	X		40307			S	ept	ember	8, 2	2006	
	4		30. Name and address of person who Eugene B. Casagra:					Pik	o. Fra	ederi	ck. Ma	1737	and '	2170	2	
<b>1</b>	Sta	te	31. Date filed (Month, Day, Year)	32. Regist		ture			-,	-4	OK, H	~ = y =		-170	_	
2	Registr	ar	Arm d	2000		200	A. N.	,								

State of Maryland / Department of Health and Mental Hygiene 29320 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** PHOEBY ELIZABETH HART TRADER /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number Examiner SAUSHUR NICOMIC If Under 1 Year | If Under 29 7. Age (In yrs. last birthday) Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Numb **Funeral** Days Months Hours 1□M XX 87 Director 219-34-3592 11/30/1918 Virginia Usual Residence of Decedent Maryland 10a State 10h Count 10c. City, Town or Location 10d. Inside City Limits r then "natural", or Iteme 23a or 28a-f ehow the Medical Examinar must be notified at 1 Yes 2 □ No Snow Hill Worcester MD Director the 10f. Zip Code 10g, Citizen of What Country? 10e, Street and Number 21863 USA 102 South Washington Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify Specify: White þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry iled within Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: if Item 27 is marked other then Elementary/Secondary (0-12) College (1-4or 5+) Clerk Retail 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Janie Elizabeth Marshall Dennis T. Hart 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1863 19a. Informant's Name/Relationship (Type, Print) 102 S. Washington Street, Snow Hill, MD Joanne Groff/ daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages:
Depertment of H
Important: If Ite
eny injury or ot
once. 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Remson Meth. Cem. 8/27/2006 Pocomoke, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Muhus Holloway Funeral Home, Professional Assoc. 103 Linden Ave., Pocomoke, MD 21851 Can 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Anovic bra .-INJUCT /Medical Due to (or as a consequence of): Examiner hours aust Cardine Sequentially list conditions, if arry, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of): certificate be executed burial-transit In.lo peoplanting that initiated events resulting in death) Last ettending physician and Due to (or as a consequence of) 68760, Physician/Medical COPD yens use as the IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the detached f o signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ete has been sign page 2 should be 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Wasan certificete has 2 **N**o 1 ☐ Yes Physicien: 25. Was case referred to medical 26. Place of Death Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA this Division of After this funeral of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hoepital or At within 24 hours after d To the Funerel Direct filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. License number Felder, D.O. 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertition License# H0064534 30. Name a dadress of person who completed cause of death (Item 23a) (Type, Print) BA 2 100E CARROLL ST. SALISBURY, M.J. 21801 Michael FElder D.O. 31. Date filed (Month, Day, Year) State AUG 3 0 2006 Registrar

DHMH 17 Rev 1/2001

19-34

Phoeby Trader

			For State Registrar		State o	of Mary		artment of ertificate of		nd Mental Hy	ygiene Reg. No.		
			1. Decedent's Name	e (First, Middle, La	ist)					2. Date of D	eath Day	Year	3. Time of Death
	Physicia		Hil	da	Agr	nes		Twigg		Augus			8:20 A M
	/Medic Examin		4a. Facility Name (/	f not institution, giv	ve street and nu	ımber)		4b. City, Town,	or Location of I			County of Death	
			Cumberla	and Villa	Nursir	ng Cen	ter	Cumber	land			Allegany	<i>I</i>
	Funeral		5. Social Security N	lumber 6.	Sex	7. Age (In	yrs. last birthda	Months Days		Hrs. 8. Date of B	irth Day, Year)	9. Birth Cou	place (State or Foreign ntry)
	Director		220-48-63	70	1□M 2∏F	89	Yrs.			11/12		Mary	land
	pur 😼		Usual Residence of 10a. State	Decedent 10b. County		100	c. City, Town or	ocation					10d. Inside City Limits
	sho	2					M←	Conso					1 ☐ Yes 2 ☐ No
	the N	ect	MD 10e. Street and Nu	Alleg	gany		FIC	Savage			10a. Citi	izen of What Cou	ntry?
	with 6 or	ā		32 Upper	Sunnysi	ide Ro	ad. NW		21545	5		USA	
	ns 23	era	11. Marital Status	opper	12. Was Dec	edent Ever		. Was Decedent of		n? (Specify Yes or N Puerto Rican, etc.)	10-	14. Race · Ameri	
36	be filed within 72 hours after death with the Maryland ital Hyglene. Id other then "natural", or Itams 23e or 28e-f show event. The Medical Exarding or instituted at	by Funeral Director		ied 2 Married	Armed F 1  Yes If Yes, G Year or I	2 XNo		If Yes, specify Cu 1 ☐ Yes 2 ☐ No		Puerto Rican, etc.)		Black, White, Specify:	
21215-0036	hour turel	ed t	X	15. Decedent's E			16a, Dec	edent's Usual Occi	pation		16b. Ki	ind of Business/Ir	<u>White</u>
5	in 72	Completed		cify only highest gi	ade completed,		(Giv	e kind of work don DO NOT use retir	e during most o	of working			ŕ
212	lene.	шо	Elementary/Seco	ondary (0-12)	College	(1-4or 5+)		Homemak	er			Home	
D	filed Hygi other	BeC	17. Father's Name	(First, Middle, Las	t)	<del></del>				s Name (First, Midd	le, Maiden	Sumame)	
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ary	should and Men a marke umatic		19a. Informant's N	ame/Relationship	(Type, Print)		19b. Ma	ling Address (Stree	and Number	or Rural Route Num	ber, City o	r Town, State, Zi	p Code)
	7. ₹ # d		Sharon R	obinette	/ daug					ırms Lane,	01dt	town, MD	21555
J.	of Healitem		20a. Method of Dis			2	Ob. Place of Dis cemetery, ci	oosition (Name of ematory or other pi	ace)	Date	20c. Lo	ocation - City or T	own, State
E	Pages nent of P ant: If its			☐Cremation 3 l			Sunset N	Memorial	Park   0	9/01/2006	Cur	berland	. MD
altimore,	permit. Pages Department of Importent: If i any injury or once.		21. Signatur of Fu	uno al Service Lice	ensee						-		Home, P.A.
8	89 = 9		Tol	ur C.	alla	me				et, Cumbe		1, MD 2	1502
	Pnysician /Medical Examiner	iner	shock, or heal immediate Cause disease or condition resulting in death)  Sequentially list or any, reading to in cause. Enter Undecause (Disease or Cause (Disease or Cause) (Disease or Cause)	on financial form	aDue to	CU) (or as a co	PRENT nsequence of):	ASPI	RATI	ON PUE	UM O	NIA	Interval Between Onset and Death
68760,	icate be executed physician and s the burial-transit	edicai Examiner	that initiated event resulting in death)	s 🔳	c. Due to	or as a co	nsequence of):						
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of Vital	Physician: The this certificate ral director, page	Be	25. Was case refe examiner?	rred to medical						of Death (Check only	v one)		
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sio	Attending r death. actor: After y the fune	cati	2 Accident	investigati 6 ☐ Could not			411 4		□Yes 2□N		/Ciront ar	ad Number of Du	ral Route Number,
Division	s after d	Certification:	4 Homicide	determine	d 200. Flac	ding, etc. (S		street, factory, offic	B	City or 1	own, State	a)	ai noute ivulliber,
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	1			1		0		Da	J233	371	87	30106	
	nus		30. Name and add	dress of person who			_		ue, Cur	mberland,	MD	21502	
		ate rar	31. Date filed (Mo.		32.	Registrar's	Signature	booth		·		-	

State of Maryland / Department of Health and Mental Hygien 2006 29322 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Trail, Sr. Eugene Darhl 9:40 A September 1. 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Allegany NE Flintstone 31401 Green Meadow Lane, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 ₹M 2 □ F Months Days 66 Director 220-38-0654 06/02/1940 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow other traumatic event, the Madical Examiner hast be notified at 1 ☐ Yes 2X No rector Flintstone Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ā 21530 USA 31401 Green MEadow Lane, NE or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status permit. Pages 1 and 2 should be itied within 72 hours after c Department of Health and Mental Hygiene. important: If item 27 is marked other than "naturel", or Iten eny injury or other traumatic event, the Maximal Examinations. Black, White, etc. TYes 2 No 1962-1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify à 3 Widowed 4 Divorced Year or Dates: 1964 White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer Union 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Schriever Trail Marv Elizabeth Henry John ဨ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 31401 Green Meadow Lane, NE., Flintstone, MD 21530 Shirley A. Trail / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Piney Plains UMC Cem. 09/06/2006 Little Orleans, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatu s of uneral Service Licenses 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications at at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dure on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit certificate be executed Due to (or as a consequence of) Box 68760, the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown been signed by Part II. Other significant conditions confiduting to death but not resulting in the underlying cause giver in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 No 1 Yes Hospital or Attending Physician: 44 hours after death. Funeral Director: After this certified funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled in Let Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) VIA 6/10A September 1, 2006 D19318 .D., 517 Oldtown Road, Cumberland, MD 30. Name and address of person who dempleted stuse and address of person who dempleted stuse and address of person who dempleted students. Nagaratnam Ranjithan, M.D., 22/2 31. Date file Chops, Pay 5 02006 32. Registrar's Sighature State Registrar

			For State Registrar	State of I	Maryland	-		t of Hea e of De		Mental Hyg	iene •g. No. 2006	5 29323
ţ.	Physicia	an	1. Decedent's Name (First, Mide	_						2. Date of Dea Month	Day Year	3. Time of Death
( )	/Medic	al	Charles  4a. Fecility Name (If not instituti	Lee	05)	1.		t, Sr.	cation of Death		26, 2006 4c. County of Dea	7:25 A M
1	Examin	er	9 Asbury Aven		61/		, ,	Vale	Cation of Deam		Alle	
\$ 80 m	Funeral		5. Social Security Number 220–70–2988		Age (In yrs. I	ast birthday) Yrs.	If Under Months	1 Year If	Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year) 9. Bir	thplace (State or Foreign buntry)
4	Director		Usual Residence of Decedent  10a, State 10b, Count			, Town or Lo	l l			02/20/1	950 Mar	yland  10d. Inside City Limits
	Maryla -f shov lied at	tor		Legany	Too. Oity	, rown or Lo	LaVa]	Le				1 □Yes 2 No
	r 28a	Director	10e. Street and Number	0 0			10f. Zip	Code		1	0g. Cilizen of What C	ountry?
	th wit		9 Asbury	Avenue, Lot	#16			21	1502		USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23s or 28s-f show eny injury or other traumatic event, the Madical Examinar must be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Ma 3 Widowed 4 X Divorce	If Yes Give	es? No		Was Deced If Yes, spec 1 Yes		nic Origin? (Sp Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	Specify:	
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2121	d within piene. r then	omp	Elementary/Secondary (0-12)	College (1-4	or 5+)		epa <b>i</b> rn				Auto Body	<b>y</b>
Maryland	be file ntal Hyg od othe event,	Be	17. Father's Name (First, Middle	e, Last) Frank		Tippe	h++		. Mother's Nam Ermina		Maiden Sumame) elia	Harrison
aryle	should nd Mer marke umatic	2	Joseph 19a. Informant's Name/Relation								r, City or Town, State,	
e, M	1 and 2 Health a em 27 is ther trac		Cheryl Fulton 20a. Method of Disposition	/ friend	20b. Pl	lace of Dispo	sition (Nan	ne of		416, LaVa	ale, MD 2	1502 Town, State
Baltimore,	Pages nent of int: If it		1 Burial 2 Cremation 4 Donation 5 Other		ate Cé	emetery, crei	matory or o	ther place)	y 08/28		Cumberlan	
Balti	permit. Departn Imports eny inju		21. Signature of Fuoral Service	e Ligensee		22	2. Name an	d Address o	f Facility Ada	ams Famil		Home, P.A. 21502
	Physician		23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition	or complications that cau st only one cause on eac	sed the death h line.			e of dying, s	_	or respiratory arr	est,	Approximate Interval Between Onset and Death CimumH
	/Medical Examiner		resulting in death)	Due to (or	as a consequ				A7717	0		5 VISMOS
13	pe lis	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or	as a consequ		-,-	11(1	71.71.1			5 /(11/5)
,092	ate be executed tysicien end he burial-transit	cal Examiner	that initiated events resulting in death) Last	c. Due to (or	as a consequ	uence of):						
	g phy: as the			0.								
.O. Box	The law requires that the death certifica ete has been signed by the ettending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2 Fetal	death 3[	⊒Ectopic pr ⊒ Other <i>(sp</i>				23d. Date of de Month	livery Day Year
rds, P.	w requires that t been signed by should be detai	ρ	Part II. Other significant condi	itions contributing to deat	th but not resu	ulting in the u	inderlying c	ause given ii	n Part I.		bacco use contribute t es 2 DNo 3 P	o the cause of death? robably 4 []Unknown
l Records,		Completed								24a. Was a autop: perfor 1 Yes	med? prior to death?	utopsy findings available completion of cause of
Vital	icien: Th certificete rector, pag	Be	25. Was case referred to medie examiner?						S. Place of Dea	th (Check only or	ne)	
of	Physicien: r this certific ral director,	. To	1 Yes 2 No	Hospital: 1 ☐ Inp		ER/Outpatrer			4 Nursing H		ence 6 Other (Spe	ecify)
ou	Attending r death, sctor: After by the funer	atlon	1 Matural 5 ☐ Pend		Day Year)	Injury	M	8c, Injury al Work? 1 ☐ Yes	2 🗆 No	200. 00301100 11	ow inquiry occurred	
Division	after des Directo	Certification:	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	mined 289. Place of	Injury - Al ho , elc. (Specify	ome, farm, st	reet, factory	, office		28f. Location (S City or Tow	treet and Number or R n, State)	ural Route Number,
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely illed in by the funeral director.	edical C	29a. Certifier 1 🔀 Certification (Check only 2 🗋 Medicone)	ying Physician: To the basial Examiner: On the basiand manner	est of my kno is of examinat r stated.	wledge, deat tion and/or in	h occurred ivestigation	at the time,	date and place, on, death occur	, and due to the c rred at the time, c	ause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the To the To the Complet	Me	29b. Signalure and title of cert	tion	\			. License nu		ž	29d. Date signed (Mon	
)			•	1/				D50844	+		August 2	8, 2006
	nes		30. Name and address of personal T. L.	on who co pated cause overia M.D.				ve. Cu	umberlan	nd. Mary	land 2150	2
	Sta Regist		Dr. David Glant (Manufa Dale Va	ar) 32 Rec	gistrar's Signa	lure		127.				

			1 - For State Registrar	State of Ma	•	•	nt of Heali te of Dea			iene _{eg. No.} 2 ()	06	29324
	Physici /Medic Examin	al	Decedent's Name (First, Middle, Last)     BRIAN JOHN U     Aa. Facility Name (If not institution, give s	DELL treet and number)		4b. City	, Town, or Loca	tion of Death	2. Date of Deal Month AUGUST 18	Day 3, 2006 4c. County		3. Time of Death 4:30P
	Funeral Director		3405 QUEENSBOROUGH 5. Social Security Number 394-72-1131 6. Sex		(In yrs. last birt	hday) If Under		nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day AUGUST 2		9. Birthp Cour	place (State or Foreign offic) OWA
	ס	tor	Usual Residence of Decedent  10a. State 10b. County  MARYLAND MONTGOMER	RY	10c. City, Town						1	0d. Inside City Limits 1 Ayes 2 No
	ath with the s 23s or 28s wat be not	rai Director	10e. Street and Number 3405 QUEENSBOROUGH DF				20832	0.1-1-2.10-	UN	Og. Citizen of V	ES OF	AMERICA
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. and Mental Hygiene. is marked other than "natural; or items 23e or 28e-f show aumatic event, it e Medical Exa⊤frer must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒N If Yes, Give Year or Dates:		13. Was Dece If Yes, sp	ecify Cuban, Me	xican, Puerto	ecify Yes or No- Rican, etc.)		ck, White, เม	can Indian, etc. HITE
Baltimore, Maryland 21215-0036	d within 72 h giene. r than "natu	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)			Decedent's Usi (Give kind of w life. DO NOT)	ork done during use retir <del>e</del> d)	most of work	ing	16b. Kind of Bu		ŕ
yland .	should be filed ind Mental Hygi marksd other umatic sysnt, ii	To Be C	17. Father's Name (First, Middle, Last) WILLIAM SYLVESTER UI					DORIS M	e (First, Middle, IAE BOWDEN			
re, Mar	permit. Pages I and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic syongs.		19a. Informant's Name/Relationship (Ty, LISA LYNN UDELL - WIFE 20a. Method of Disposition		20b. Place of		NSBOROUGH	DRIVE,	al Route Number OLNEY, MD Date			
altimo	permit. Pages Department of Important: If I sny injury or once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License			OLN CREM		UNK Facility HIN	ES RINALD	BRENTWOO		
			23a. Part1. Ease the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	ie cause on each lin	the death. Dorne.	ot enter the mo	de of dying, suc		or respiratory arr			Approximate Interval Between Onset and Death MINUTES
8760,	Medical Examiner transit the purial-transit	dical Examiner	Sequentially list conditions, if any, leading to unmediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	). Dua to (or as	a consequence of a consequence of a consequence of	赤.						
O. Box 6	ne death certifi the ettending thed for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 ⊟Ectopic   5 □ Other (s					te of delive	ery Day Year
ords, P.	w requires that the been signed by should be detact		Part II. Other significant conditions cor	ntributing to death bu	ut not resulting ir	the underlying	cause given in l	Part I.				he cause of death?
Vital Records,	hyeiclan: The law n nis certificete has be t director, page 2 sh	Completed								med? 2 ☐ No	Were auto prior to co death? 1 Yes	opsy findings available impletion of cause of
	ng Phyeiclar Iter this certif ineral directo	on: To Be	25. Was case referred to medical examiner?  1 XYes 2 No  27. Manner of Death  1 XNatural 5 Pending	lospital: 1 ☐ Inpatie 28a. Date of Inju. (Month, Day	nt 2 ER/Ou ry 28b. 1	tpatient 3 C	Other		th (Check only or ome 5 \( \) Reside 28d. Describe h	ence 6 Oth		(y)
Division	pital or Attending Fours after death. Intel Director: After filled in by the funer.	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	ury - At home, fa	m, street, facto	1  Yes	2 □ No	28f. Location (S City or Tow		per or Rura	al Route Number,
	Hos Fur Bely	edical	29a. Certifier 1 Certifying Physical Check only one)		examination an	d/or investigation	n, in my opinior	i, death occur	red at the time, o	late and place,	and due to	o the cause(s)
) 1	To the complete	M	29b. Signature and title of certifier	ih	onth (lan on)		9c. License nun DO9834	nber	2	9d. Date signe AUGUST		
	Sta Regist	ate	BARRY ROSENBAUM, MD  31. Date filed (Month, Day, Year)  AUG 3 0 200	3720 FAR	RAGUT AVE		NGTON, MI	20895				

State of Maryland / Department of Health and Mental Hygien 2005 29325 For State Registrar 20b, per f.h., bg, 8/31/06 Certificate of Death amend item # Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Yeer 1000 A-M **Physician** 2006 White /Medical ma. 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wiconico Anchorag If Under 1 Year If Under 24 Mrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours Months 1 M 200F 18-86-5388 59 -25-1947 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Items 23a or 28e-f show any injury or other treumatic event, the Medical Examination and be notified at once. 10a. State MD Salisburg 1 🗗 ves 2 🗆 No Wi. comice Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21801 105 HaLE imes Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify. ۵ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DQ NOT use retired) Elementary/Secondary (0-12) Cotlege (1-4or 5+) ousewite aborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 piman Talc 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ND 2639 1221 GEHING + Make Maynond ( 20a. Method of Disposition Gale 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 09-02-06 1 Burial 2 ☐ Cremation 3 ☐ Removal from State MT. Zion Cemetera 4 ☐ Donation 5 ☐ Other (Specify) M'ncess 27. Name and Address of Facility
30639 Hampeler 21. Signature of Funeral Service Licensee tuncial Home Mon Mr 21857 Princess 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure/List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIOMYOPATITY Pnysician /Medical Due to (or as a consequence of): **Examiner** MULTIPLE SCLEROS 1 cars Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 1 Yes 2 No 9 Unknown 9 Unknown s been signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performe certificate 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 | Mirsing Home 5 | Residence 6 | Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 2 (his 28a. Date of Injury (Month, Day Year) After thi 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Anatural Injury 5 Pending 2 🗌 No death. investigation 1 Tyes 2 Accident Director: / 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of centifie 005135 28 K 2006 NATESAN DR. USHA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALISBURY 1415 5. DIVISION 31. Date filed (Month, Day, Year) 32. Registar's Signature State Registrar AUG 3 1 2006

			State of Maryland/De 1- State Amend #18&19a Per FH G859 9/12 Registrar	partment of Health and Mental Hygiene entificate of Death Reg. No. 2006 29326
Ì	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Donald LaMarr Williard, Jr.	2. Date of Death Month Day Year  8 27 2006 12:10 P
	Examir		4a. Facility Name (If not institution, give street and number)  30769 Dagsboro Rd.	4b. City, Town, or Location of Death  Salisbury  4c. County of Death  Wicomico
	Funeral Director		5. Social Security Number  180-38-5941  Usual Residence of Decedent  6. Sex 1 St. M 2 F 59  7. Age (In yrs. last birtho	Months Days Hours Min. (Month, Day, Year) Country)
	Maryland a-f show	tor	10a. State 10b. County 10c. City, Town of MD Wicomico Salish	1 □Yes 2√□No
	3s or 28a	Il Director	10e. Street and Number 30769 Dagsboro Rd.	10f. Zip Code 10g. Citizen of What Country?  21801 USA
980	be filed within 72 hours after deeth with the Maryland lat Hygiene. d other then "natural", or iteme 23e or 28e-f show event, the Medical Examinar must be notified at	by Funeral		3. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 □ Yes 2 ▼ No Specify:  Specify: White
21215-0036	들 급	Completed	(Specify only highest grade completed) (C) Elementary/Secondary (0-12) College (1-4or 5+)	codent's Usual Occupation ive kind of work done during most of working e. DO NOT use retired)  countant  Car Dealership
Maryland		To Be C	17. Father's Name (First, Middle, Last)  Rev. Donald Williard	18. Mother's Name (First, Middle, Maiden Sumame)  Dorothy A. Haney Wilhelm
	and 2 stand 2 stand 2 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 to 5 stand 2 t		Jean A: Williard (wife) 307	ailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  69 Da Sboro Rd., Salisbury, MD 21801  sposition (Name of prematory or other place)  Date 20c. Location - City or Town, State
Baltimore,	permit. Pages Department of I Important: If Ite eny Injury or of		1 🗆 Buriai 2 🗷 Cremation 3 🗀 Hemoval from State	nlopen Crem. 8/29/2006 Frankford, DE  22. Name and Address of Facility The Burbage Funeral Home
8	80E 9		23a. Part 1. Enter the disease, or complications the caused the death. Do not shock, or heart failure. List only one cause an each line.	108 William St., Berlin, MD 28111
	Physician /Medical Examiner	ner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying	Onset and Death
,0928	The law requires thet the death certificate be executed site been signed by the attending physicien and been signed by the attending physicien and been deteched for use as the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last c	
P.O. Box 6	thet the death certific led by the attending p deteched for use as i	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 4   Pregnant at time of death 9   Unknown	3 Ectopic pregnancy 23d. Date of delivery 5 Other (specify) Month Day Year
	v requires the been signed I should be del	þ	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown
of Vital Records,		Completed		24a. Was an autopsy findings available prior to completion of cause of death?  1 Yes 2 No 1 Yes 2
ion of Vita	To the Hospital or Attending Physician: Th within 24 hours effer death. To the Funerel Director: Affer this certificate completely filled in by the funeral director, peg	atlon; To Be	25. Was case referred to medical examiner?  1	
Division	Hospital or Attending 124 hours efter death. Funerel Director: After tely filled in by the funer	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	street, factory, office  28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or A within 24 hours effer To the Funerel Directory completely filled in by	ledical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, companies to the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desired form of the desir	eath occurred at the time, date and place, and due to the cause(s) and manner as stated.  If investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year) 8-29-06
β	A 10+1		30. Name and address of person who completed cause of death (Item 23a) (Ty  David E. Conarl, WD. Coastal Hou  31. Date filed (Month, Day, Year)  32. Registrar's Signature	D26278 8-29-06 pe, Print) più po Box 1733 Solut, MD 21802
	St: Regist	ate rar	AUG 3 0 2006	god -

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiens 006 29327 Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Deta of Death 3. Tima of Death Day ROBERT HENRY WANTZ Month Vaar **Physician** 7 2006 September 1:30 PM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 15809 Old Frederick Road Emmitsburg Frederick County If Under 1 Yaar If Under 24 Hrs 5. Social Security Number 6. Sax 1 ☑ M 2 ☐ F 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Days Months Hours 215-26-1097 77 Vrs 1928 Maryland Director 18, Usual Rasidance of Decedant permit. Pages 1 end 2 should be filed within 72 hours efter death with the Marylend Depertment of Heelth and Mantel Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumetic event, the Macical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits Maryland Frederick County Emmitsburg 1 ☐ Yas 2/☐ No Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 15809 Old Frederick Road 21727 United States Funerai 12. Was Dacadant Evar in U,S. Armed Forcas? 13. Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - Amarican Indian, Black, Whita, atc. 1 X Yas 2 No If Yas, Giva Korean Yaar or Datas: Cores 1 ☐ Naver Marriad 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Conflict Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) plasterer plastering 8 17. Fathar's Name (First, Middle, Last) 18. Mothar's Nama (First Middle Maiden Sumeme)
Henrietta Bowers Be John Russell Wantz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Straet and Numbar or Rural Route Number, City or Town, State, Zip Code) Robert L. Wantz / SOU 16617 Annandale Road Emmitsburg, Maryland 21727 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata Sep. 8 2006 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, Maryland Smithsburg Crematorium 22. Nama and Addrass of Facility Skiles Funeral Home 21. Signature of Funaral Sarvice Licensas 210 West Main Street Emmitsburg, Md. 21727 www 23a. Part1. Entar the diseasa, or complications that ceusad the daath. Do not entar tha moda of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Death **Physician** Immediate Causa (Final disaase or condition rasulting in death) /Medical SUDDEN DEATH Examiner Due to (or as a consequence of): Physician/Medical Examine CHONIC OBSTRUCTIVE The law requires that the death certificate be axecuted attanding physician and for usa as the bunal-transit Sequantially list conditions, if any, leading to immediata ceusa. Enter Undartying Ceuse (Diseasa or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of): sate has been signed by the a pege 2 should be datached Part II. Other significant conditions contributing to death but not rasulting in the underlying causa given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 □ No 3 Probably 4 Unknown à 24b. Wara autopsy findings availabla prior to completion of cause of daath? Completed 24a. Was an autopsy performed? 1 ☐ Yas 2X No 1 Tyes 2 No. certificate or Attending Physician: funeral director, Be 25. Wes case rafarred to medical axaminer? 26. Placa of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5X Residance 6 ☐ Othar (Specify) ဥ 1 Yas 2 No this 28a. Data of Injury (Month, Dey Year) 27. Mennar of Deeth 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 DNatural 5 Pending eftar deeth. 1 ☐ Yes 2 ☐ No investigation 2 Accidant tha 6 Could not be detarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 Suicida 28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours e 29a. Certifiar 1 X Certifying Physician: To the best of my knowledge, death occurred et tha time, date and place, and due to the cause(s) and manner es steted.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha causa(s) and manner statad. edicai completaly (Check only 29c. Licansa number 29b. Signatura and title of certifian 29d. Date signed (Month, Day, Year) MD0296368 mo

10 State

DW16147 31. Data filed (Month, Day, Year) HATEL M.O 32. Registrar's Signature

30. Nama and address of person who completed ceusa of death (Item 23a) (Type, Print)

S. WASHINGTON STE

Registrar **DHMH 16 Rev 6/95** 

**ORIGINAL** 

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

AUG 3 1 2006

	•	1 - For State Registrar	State of M	arylan				ealth ar Death			g. No2	106	293	2
hysicia		1. Decedent's Name (First, Middle, La	ist)						2	. Date of Death Month	Day	Year	3. Time of	Death
/Medic		BRIDGET D. ZIDAR								AUGUST 25	<del></del>		9:30	P :
xamine		4a. Facility Name (If not institution, give	ve street and number)			4b. City		Location of [				nty of Death		
		12503 EASTBOURNE				Iá I Imala		R SPRING				NTGOMER		F
neral			Sex 7. Ag 1 ☐ M 2 🖾 F		last birthday) Yrs.	Months	Days		Min.	Date of Birth (Month, Day,	Year)		olace (State o	· Forei
ector	1	212-78-0966 Usuat Residence of Decedent		86					I	MARCH 26,	1920		ANADA	
5 월		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	0d. Inside Cit	y Limi
3	ţ	MARYLAND MONTGOM	1ERY		S	ILVER	SPRIN	G					1 🗌 Yes	2 🖾 N
3	Director	10e. Street and Number				10f. Zi	ip Code			10	g. Citizen	of What Cour	ntry?	
1		12503 EASTBOURNE D	DRIVE				20	904				U.S.A.		
cer must be notified at	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	.S. 13. V	Vas Dece	edent of Hi	spanic Origin	? (Speci	ly Yes or No- can, etc.)		Race - Americ		
		1 ☐ Never Married 2 ☑ Married	1 ☐ Yes 2 ☒ If Yes, Give					Specify:		Jan 1, 51517		cify:	010.	
3	d by	3 Widowed 4 Divorced	Year or Dates:									WH	ITE	
and and	Completed	15. Decedent's E (Specify only highest gr			16a. Deced	kind of w	ork done d	during most o	f working	1	6b. Kind of	f Business/In	dustry	
2	E C	Elementary/Secondary (0-12)	College (1-4or	5+)		HOMEM	use retired AUCD	,			OL.	N HOME		
		12 17. Father's Name (First, Middle, Last	t)			HOMEN	AKEK	18 Mother's	Name (	First, Middle, M				
	Be	PATRICK JOSEPH DO								EN KENNED				
matic	ို	19a. Informant's Name/Relationship			19h Mailin	a Addres	s (Street :			Route Number,		wn State Zir	(Code)	
1		JAMES J. ZIDAR - HUS			1	•				ER SPRING				
Injury of other treumatic e.	!	20a. Method of Disposition	DDAND	20b. F	Place of Dispo				Dat			on - City or To		
<b>D</b>		1 ☑ Burial 2 ☐ Cremation 3 [						1	100 /	2006	DT T110M		OT NT A	
Injury		4 □Donation 5 □ Other (Special Signature of Funeral Service Lice	-	ARL]	INGTON N.			ETERY S	9/20/			ON, VIR		_
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cian dical		disease or condition resulting in death)	a	•	NOWN PRI	MARY						-		
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Ā	cal Ex	resulting in death) Last	Due to (or as	a conseq	juence of):									
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nse.	Physician/Med	tF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			1Ectonic	pregnancy				1	Date of delive	•	
of be	Sicient	in the past 12 months? 1 ☐ Yes 2 🖾 No	4☐Pregnant a			Other (s						Month	Day 1	/ear
tache	, P	9 Unknown	3 CHRIOWII											
Pe	5	Part II. Other significant conditions HYPERTENSION	contributing to death t	out not res	ulting in the u	nderlying	cause givi	en in Part I.		23e. Did toba			he cause of do babty 4 K∑l	
should	ete									24a. Was an	24	h Were auto	psy findings	avails
irector, page 2 s	Completed									autopsy	ed?		impletion of c	
or, p	Ö	25. Was case referred to medical						26 Place o	f Death /	1 Yes 2 Check only one		1 🗆 163	2   NO	
direct	To B	examiner? 1 ☐ Yes 2 ☒ No	Hospital:	ent 2	ER/Outpatien	nt 3 🗆 🗆	Oth Oth			5 🖾 Resider		Other (Speci	(v)	
		27. Manner of Death	28a. Date of Inju	ury	28b. Time of		28c. Injun Wor			d. Describe how			,,	
(B)	č	4 (This was C C Deading	(Month, Da	ay rear)	tnjury	М		k? Yes 2∐No	,					
unera	ation	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation		iune. At h	ome, tarm, str	eet, facto	ory, office		28	t. Location (Str. City or Town,		ımber or Rur	al Route Num	ber,
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				For Amend It	tens	State of Mag	(land (De) C	partme859f ertificate o	<b>09715/06d</b> f Death	Antal Hyg	2006	29330
	4.0	Physicia	100	1. Decedent's Name (First, Mide	dle, Last)	MICH	+AE1	ASH	E	2. Date of Death	Day Year	3. Time of Death
	*	/Medic Examin		4a. Facility Name (If not instituti	on, give s		ACL	4b. City, Town	n, or Location of Death		4c. County of Death	110011
	Sept. Sept.		6 ⁾	5. Social Security Number	6. Sex		n yrs. last birthda	If Under 1 Ye	9LTIMOR ar If Under 24 Hrs.		N/A 9. Birthp	lace (State or Foreign
	38.	Funeral Director		213-08-4889		M 2 F	29 Yrs.	Months Day		8. Date of Birth (Month, Day, April 5	Sear 977 MA	RYLAND
		and		Usual Residence of Decedent  10a. State 10b. Coun	ty	1	Oc. City, Town or	Location		<i>y</i>	1	0d. Inside City Limits
		death with the Maryland ms 23a or 28a-f show rinust be notified at	tor	MARULADA	NI	A		BAG	TIMOR			1¢ŽiYes 2 □ No
		or 284	Funeral Director	10e. Street and Number	10	1- 1-	# 10	10f. Zip Cod		1	Og. Citizen of What Cour	itry?
O		ns 23s	erai	10 8 GREEN		NE CT. A	er in U.S. 1	3. Was Decedent	2/244 of Hispanic Origin? (S Cuban, Mexican, Puert	pecify Yes or No-	14. Race · Americ Black, White,	
K	98	or Itan	y Fur	1 Never Married 2 M		Armed Forces? 1 ☐ Yes 2 💢 No If Yes, Give		1 ☐ Yes 2 🔼		o mican, etc.)	Specify: /2	1001
4	215-0036	within 72 hours after ene. then "netural", or Its he Medical Examina	ed by	3 Widowed 4 Divorce	ent's Edu	Year or Dates:	16a. De	ecedent's Usual Oc	cupation	dina	16b. Kind of Business/In	dustry
- 1	215	ithin 72 nen "nen	Completed	(Specify only high Elementary/Secondary (0-12		College (1-4or 5+)	(G III	e. DO NOT use re	ine during most of wor tired)	T. O	Erpouson	) TRUCKING
ne	d 21	filed will Hygien other th		12 HFGRADE 17. Father's Name (First, Middle	le, Last)		1/	RUCK	18. Mother's Nar	ne (First, Middle, I		D IKUCNIC
3	/lan	Mental Mental arked o	To Be	GLEN M	,	ASHE			PAME	ELA	R. Sm	11774
3	Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene. Item 27 is marked other then "natural", or Itams 23a or 28a-1 show other traumatic event, The Medical Examinar must be notified at		19a. Informant's Name/Relatio	nship (Ty	pe, Print)	19b. M	ailing Address (Str	_ /	0 00 1	; City or Town, State, Zip	Code)
0		s 1 and f Healt fem 2		20a. Method of Disposition	וויזע	1 MUKANDMO	20b. Place of Di	sposition (Name of crematory or other	ETONS /	DALTI	20c. Location - Tity or To	own, State
( /	Baltimore,	nit. Pages artment of ortant: If It injury or o		1 ≥8urial 2 □ Crematio 4 □ Donati 5 □ Other		Removal from State	-	US CEN	ETERY 09-1	15-06	ARBUTUS	MARYLAND
	Balt	permit. Depart Import any inj		21. Signature of Furniral Servi	ce Liceos	* AN		Joseph A	thess of Facility 2.	Ir. Funer	ilton Avenue al Home B	
		* *		23a. Part1. Enter the disease, shock, or heart failure. L	or compli	ications that caused the	ne death. Do not	enter the mode of	dying, such as cardia	or respiratory arr	est,	Approximate Interval Between Onset and Death
		Physician /Medical		Immediate Cause (Finat disease or condition resulting in death)		se 12	we a	1. 22	er le	p. lepse	1	
	£ 14	Examiner			1	Due to (or as a	consequence of):			<u> </u>		
		D 15 ¢	iner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1	Due to (or as a	consequence ot):					
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	3760,	a × a	cal			d						
Î	Box 68	leath certificat attending phy I for use as th	/Mec	IF FEMALE: 23b. Was decedent pregnant	2	23c. If yes, outcome of			- Melle		23d. Date of deliv	өгу
	Bo	Physician: The law requires that the death certifica t this certificate has been signed by the attending ph ral director, page 2 should be detached for use as th	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No		1□Live birth 2 4□Pregnant at ti 9□Unknown		3 ☐ Ectopic pregn. 5 ☐ Other (specif)			Month	Day Year
80	P.O.	that the de led by the a detached t	Phy	9 ☐ Unknown  Part II. Other significant cond	ditions co	ntributing to death but	not resulting in the	ne underlying cause	e given in Part I.	23e. Did to	bacco use contribute to t	he cause of death?
#26,27,28c,28a	rds,	w requires tha been signed should be del	ed by	asthma						1 🗆 Y	es 2 No 3 Pro	bably 4 Unknown
28	eco	e law requ has been je 2 shouk	Completed							24a. Was a autop perfor	sy prior to co	opsy findings available impletion of cause of
27	al H	ician: The certificate b rector, page	e Cor	25. Was case referred to med	lical				26 Place of De		No 1 ☐ Yes	24/10
26	f Vii	Physicia this certi	To Be	examiner?	-	Hospital: 1 ☐ Inpatien	t 2 ER/Outp	atient 3 DOA			ence 6 ☐Other (Speci	fy)
中	o uc	ling Pt		27. Manner of Death 1 ANatural 5 ☐ Per		28a. Date of Injury (Month, Day			Injury at Work? 1 ☐ Yes Z ANO	28d. Describe h	ow injury occurred	
	Division of Vital Records,	Attending er death. rector: After by the funer	Certification:	3 Suicide	estigation ald not be ermined	71 (79	y - At home, farm	n, street, factory, of		28f. Location (S City or Tow	itreet and Number or Rui n, State)	ai Route Number,
	Ö	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a Certifier 1 № Certi	fyina Phy	ysician: To the best of	my knowledge,	death occurred at ti	he time, date and place	e, and due to the o	cause(s) and manner as	stated.
		he Hos in 24 ht he Fun pletely	edical	(Check only 2 Medi	cal Exam	iner: On the basis of e	examination and/	or investigation, in	my opinion, death occ	urred at the time, o	date and place, and due	to the cause(s)
4		To t To t	Σ	29b. Signature and title of cer	tifier	- B			cense number	(0	29d. Date signed (Month	Te
ii		6		30. Name and address of per	son who d	completed cause of de	ath (Item 23a) (T			~	- 4-70	4
				Victor M	adr.	id mb	700 C		d ± 20	o Cato	abuille H	A
	1	St Regis	tate trar	31. Date filed (Month, Day, Y. SEP 1 5 2	006	32. Hegistral	r's Signature	all I				

#### Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Darrell Artis 1- For State Certificate of Death Registrar Date of Death ent's Name (First, Middle,Last Physician/ Month Day September 7, 2006 2209 hrs **Medical Examiner** 4c County of Death 4b. City, Town, or Location of Death Baltimore 7184 McClean Boulevard 9 Birthplace (State or If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYY) . Age (In yrs. last birthday) 5. Social Security Number **Funeral** Directo Country) Usual Residence of Decedent 10b. County City Town or Location Yes 2 28a-f show s 23a or 28a-f shov e notified at onee. Director 10g. Citizen of What Country Street and Number Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-, or items 2 r must be r If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes Yes 2 No specify Divorced If Yes. Give Year item 27 is marked other than "natural", traumatie event, the Medical Examiner à 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life DO NOT use retired) ges 1 and 2 should be filed with of Health and Mental Hygiene If item 27 is marked other th Be Baltimore, MD Other Specify Signature of Funeral Service Licenses Part I. Enter the disease, or complications that caused the death. Do not enter **Physician** Between Onset and failure. List only one cause on each line /Medical Death a Multiple Gunshot Wounds Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and transi Physician/Medical UNPENDED AMENDED sician burial -Box 68760, 23d Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I <u>О</u>. ۵ Yes 2 V No 3 Probably 4 Completed of Vital Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? No Yes 2 26 Place of Death (Check only Fo the Hospital or Attending Physician: 25. Was case referred to medica Be Other₄ examiner? Residence 6 V Other: Scene ER/Outpatient 3 DOA Nursing Home 5 Inpatient 2 1 V Yes 2 28a Date of Injury (Month, Day Year) Sep 7, 2006 28c. Injury at Work' 28d Describe how injury occurred 28b Time of Injury 27. Manner of Death Subject shot Certification 2149 hrs Natural Yes 2 V No Pending Funeral Director: 2 Accident Investigation 28f Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide 7182 McLean Boulevard, Baltimore, MD determined (Specify) Parking Lot 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29c License numbe 29d Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E. September 8, 2006 30 Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Melissa Brassell, MD Assistant Medical Examiner 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registra

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_			1- State of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department / Department / Department / Department / Department / Departme	rtment of Healt			giene Reg. No. 2	106	29332
	Physici /Medi		Decedent's Name (First, Middle, Last)     VIOLA AMELIA BORAM			2. Date of Dea Month Septemb		Year 2006	3. Time of Death 01:15 a ^M
	Examir		4a. Facility Name (If not institution, give street and number)  Greater Baltimore Medical Center	4b. City, Town, or Local Towson	tion of Death			y of Death	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 TF 96 Yrs.		nder 24 Hrs. urs Min.	8. Date of Birt Month Da Jan. 23	, 1910	9. Birthp Court Mary	place (State or Foreign http: Land
	death with the Maryland me 23e or 28e-f show must be notified at	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loc  MD Baltimore Par	ation kville				1	0d. Inside City Limits
	h with the	al Director	10e. Street and Number 3320 Texas Avenue	10f. Zip Code 21	234		10g. Citizen of	What Coun	itry?
7003e	172 hours atter death with the Marylar "natural", or Iteme 23a or 28a-f show idical Examinar must be notilied at	d by Funeral	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:		ecify:		- 14. Ra Bla Specii	ce - Americack, White, W	ean Indian, etc. Mhite
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arylg	should and Mer s mark	5		Address (Street and No	umber or Rura	l Route Numbe		, State, Zip	
ie Č	Health Health tem 27		20a Method of Disposition 20b. Place of Disposi	ewis Avenue	_	Island	, Georgi		
Baltimore	permit. Pages 1 end 2 should be filed withir Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Monee.		4 Donation 5 Other (Specify)			5-06	Parkvi	lle,M	aryland
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	Dharistan		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.			r respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)  Due to (or as a consequence of):	east Fall				L	inknown
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68760,	tificate be executed g physicien and as the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C. Due to (or as a consequence of):  d.					(	wknom.
Division of Vital Records, P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit	by Physician/Med		Ectopic pregnancy Other (specify)				ate of delive	ery Day Year
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(3)	To the Hospital or Attend within 24 hours efter death To the Funeral Director: completely filled in by the 1	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or invegant and manner stated.	occurred at the time, dat estigation, in my opinion,	te and place, a , death occurre	and due to the o	cause(s) and m date and place,	anner as st and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License num			29d. Date signe		
	3		30. Name and address of person who completed cause of death (Item 23a) (Type, P			/ t	Deplember	13,	
	Sta	ate_	31. Date filed (Month, Day, Year) 32. Registrar's Signature		street 1	Delly	more, M	IV 2	1204
	Regist		SED 1 5 2006 Progres & Bo	aste					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 9 0 0 6 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Q** 8: 30 PM **Physician** Bertha R. Bishop 12 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 2703 Louise Ave. Baltimore Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1 / 9 / 1925 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2CX 81 Yrs. 212-20-8615 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location nem zr is marked other than "natural", or itema 23s or 28s-1 show other traumatic event, the Medical Examinar must be notified at 1X Yes 2 No Baltimore Baltimore MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen ol What Country? USA 2703 Louise Ave. 21214 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 XWidowed 4 □ Divorced Be Completed 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Social Security 1 and 2 should be filed within Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Administration secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Frei William F. Rode 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Depertment of Health ar
Important: if item 27 is
any injury or other trau Timothy E. Bishop - son 3411 Glenmore Ave. Baltimore, MD 21234 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition cometery, cromatory or other place)
Parkwood
Cemetery September 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 16, 2006 Parkville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility 8800 Harford Rd. Parkville, MD 21234 Evans Funeral Chapel 23a. Part J Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial Physician Infortion /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 € No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 1 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an certificete has autopsy performed2 1 Yes 2√No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 ☐ Yes 25 No Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner ol Death 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death investigation within 24 hours after deat To the Funerei Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitat 29a, Certifier Descrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Min Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 032543 13/06 no

State Registrar

Sertha, Bishop

101

a. Clouds St

no

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THON BONG

2. Registrar's Signature

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SEP 1 5 2006

31. Date liled (Month, Day, Year)

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Medica	al Exami		Howard Edwin Be			La	b. City, Town, o	r Location of	Septembe	er 9, 2006 4c. County of	0846 hrs
1			Atlantic General Hosp	_	oet)	"	Berlin	Location on	Death	Worceste	
<b>*</b>	Funeral		Social Security Number	6. Sex 7.	Age (In yrs. last bir	thday)	If Under 1 Yea				8irthplace (State or Foreign
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	>.	ļ	Usual Residence of Decedent  10a, State 10b, County		10c. City, Town	or Location	nn n				10d Inside City Limits
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	ryland	향	PA Delawa  10e. Street and Number	are	Nev	VLOWII	Square 10f. Zip Code			10g Citizen of Wha	at Country?
	Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene trant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	Director	8 Dudie Drive				1907	3		USA	
	with 1 ms 23s he not	<u>a</u>	11. Marital Status	Associate Core	ent Ever in U.S.	13. Was	Decedent of H	spanic Origin	n? (Specify Yes or No Puerto Rican, etc.)	o- 14 Race - White,	American Indian, 8lack, etc.
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121	d be fi lental arked event,	Be	Howard Edwin  19a. Informant's Name/Relations		110	h Mailine	Address (Stro		a Margaret er or Rural Route Nu		
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Baltimore, MD	permit. Pages 1 and 2 she Department of Health and Important: If item 27 is injury or other traumat		4 Donation 5 Other S 21 Signature of Funeral Services		Loude	22. N	lame and Addres	ss of Facility	eral Home		
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Box 68760	icate by physicate but the but	Physician/Medical	IF FEMALE. 23b. Was decedent pregnant in	he -	itcome of pregnancy		1-1 d 4b - 2	Ectopic	pregnancy	23d. Date of o	delivery Day Year
68	certif ending use as	cian	past 12 months?	I LIVE DII	nt at time of death		tal death 3 her (Specify)	Letopic	pregnancy	Month	Day , oa.
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	1 0	2	29b Signature and title of certi-	fier			29c. Lice	nse number		zau. Date signe	ed (Month, Day, Year)

O.C.M.E.

September 10, 2006

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year) 5 2006 State Registrar

DHMH 17 Rev 1/2001 OCME 2006

29b Signature and title of certifier

Zabiullah Ali, M.D.

**ORIGINAL** 

32. Registrar's Signature

Physician   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barnes   Carolyn Mae Barn	al Hygiene Reg. No 2006 29335
Sept   13 2006   Sept   13 2006   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   Sept   S	
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Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secretary   Source Secre	4c. County of Death
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The State   The Country   Too. City, Town or Location   Too. City   Town or Location   Too. State and Number   Too. State and Number   Too. State and Number   Too. State and Number   Too. State and Number   Too. State and Number   Too. State and Number   Too. State and Number   Too. State and Number   Too. State and Number   Too. State and Number   Too. State and Number   Too. State and Number   Too. State and Number   Too. State and Number   Too. State and Number   Too. State and Number   Too. State and Number   Too. State and Number   Too. State and Number   Too. State and Number   Too. State and Number   Too. State and Number   Too. State and Number   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too. State   Too	fonth, Day, Year) Country)
17. Father's Name (First, Middle, Maciden Sumame)   17. Father's Name (First, Middle, Maciden Sumame)   17. Father's Name (First, Middle, Maciden Sumame)   17. Father's Name (First, Middle, Maciden Sumame)   18. Mother's Name (First, Middle, Maciden Sumame)   18. Mother's Name (First, Middle, Maciden Sumame)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and	5. 10, 1944 Hary Land
17. Father's Name (First, Middle, Maciden Sumame)   17. Father's Name (First, Middle, Maciden Sumame)   17. Father's Name (First, Middle, Maciden Sumame)   17. Father's Name (First, Middle, Maciden Sumame)   18. Mother's Name (First, Middle, Maciden Sumame)   18. Mother's Name (First, Middle, Maciden Sumame)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and	10d. Inside City Limits
17. Father's Name (First, Middle, Maciden Sumame)   17. Father's Name (First, Middle, Maciden Sumame)   17. Father's Name (First, Middle, Maciden Sumame)   17. Father's Name (First, Middle, Maciden Sumame)   18. Mother's Name (First, Middle, Maciden Sumame)   18. Mother's Name (First, Middle, Maciden Sumame)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and	1 ☐ Yes 2√ No
17. Father's Name (First, Middle, Maciden Sumame)   17. Father's Name (First, Middle, Maciden Sumame)   17. Father's Name (First, Middle, Maciden Sumame)   17. Father's Name (First, Middle, Maciden Sumame)   18. Mother's Name (First, Middle, Maciden Sumame)   18. Mother's Name (First, Middle, Maciden Sumame)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and	10g. Citizen of What Country?
17. Father's Name (First, Middle, Maciden Sumame)   17. Father's Name (First, Middle, Maciden Sumame)   17. Father's Name (First, Middle, Maciden Sumame)   17. Father's Name (First, Middle, Maciden Sumame)   18. Mother's Name (First, Middle, Maciden Sumame)   18. Mother's Name (First, Middle, Maciden Sumame)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and	United States
17. Father's Name (First, Middle, Maciden Sumame)   17. Father's Name (First, Middle, Maciden Sumame)   17. Father's Name (First, Middle, Maciden Sumame)   17. Father's Name (First, Middle, Maciden Sumame)   18. Mother's Name (First, Middle, Maciden Sumame)   18. Mother's Name (First, Middle, Maciden Sumame)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and	es or No- , etc.) Black, White, etc.
17. Father's Name (First, Middle, Maciden Sumame)   17. Father's Name (First, Middle, Maciden Sumame)   17. Father's Name (First, Middle, Maciden Sumame)   17. Father's Name (First, Middle, Maciden Sumame)   18. Mother's Name (First, Middle, Maciden Sumame)   18. Mother's Name (First, Middle, Maciden Sumame)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and	Specify: white
17. Father's Name (First, Middle, Maciden Sumame)   17. Father's Name (First, Middle, Maciden Sumame)   17. Father's Name (First, Middle, Maciden Sumame)   17. Father's Name (First, Middle, Maciden Sumame)   18. Mother's Name (First, Middle, Maciden Sumame)   18. Mother's Name (First, Middle, Maciden Sumame)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and	16b. Kind of Business/Industry
17. Father's Name (First, Middle, Maciden Sumame)   17. Father's Name (First, Middle, Maciden Sumame)   17. Father's Name (First, Middle, Maciden Sumame)   17. Father's Name (First, Middle, Maciden Sumame)   18. Mother's Name (First, Middle, Maciden Sumame)   18. Mother's Name (First, Middle, Maciden Sumame)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and Number of Piral Name Address)   19. Making Address (Sireet and	
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autopsy performed?   1   Yes   2   No	1 Yes 2 No 3 Trobably 4 Unknown
autopsy performed?   1   Yes   2   No	24a. Was an 24b. Were autopsy findings available
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29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day,	Describe how injury occurred
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Jon Name and address of person who completed cause of death (term 23d) (type, Film)  Tim Worn's 2001 medical Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canada Canad	ly mo 21401
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature.  Registrar SFP 1 5 2006	

State of Maryland / Department of Health and Mental Hygiene 🤈 29336 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 5:46 PM 09 Kaphaela 06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Shady Grove Hospita Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Year) Hours 1 ☐ M 2 🖾 F 289-22-3419 81 January 27, Director Ohio Usuat Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or than "naturel", or iteme 23a or 28e-f ehow the Medical Examinar must be notified at 1⊠Yes 2 No Gaithersburg Montgomery by Funeral Directo Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20877 8117 Irwell Court United States death 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ≥ 2⊠No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Public Schools Teacher 17 is marked other r traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 Floyd Henry Carpenter Ethel Emma Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 525 Casey Lane, Rockville, Maryland 20850 Terri M. Miller / Cousin if Health if other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition September ō 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Department of important: if any injury or one. Montgomery Crematorium Inc 13, 2006 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final from intra-abdominal **Physician** Septic Shock disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliver 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a P.O. 1 1 ☐ Yes 2 ☐ No 9 XUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 Yes 2 No 3 Probably 4 Unknown should b Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an s certificete has b irector, page 2 sl 1 ☐ Yes 2 25. Was case referred to medical director Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 No Other: ٥ 1 🗌 Yes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this After th 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Medical Certification: 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 🗌 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by within 24 hours after To the Funerel Direct 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 00064029 2006 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Center Drive Rockville, MD Medical 990 randon 32. Resistrar's Signature 31. Date filed (Month, Day, Year) State SEP 15 Registrar

		1 - For State Registrar  1. Decedent's Name (First, Middle,		arylanu /		rtificate		2 Date of D	Reg. No.	00	2933
Physic		Margare		Batson	n			Month	. Day	2006	1:55 P M
/Medi Examir		4a. Facility Name (If not institution,				4b. City, Tow	m, or Location of Dea		4c. County		
	Que		Care Bethes				Bethesda				gomery
Funeral Director		5. Social Security Number  235-30-4108  Usual Residence of Decedent	. Sex 7. Ag 1 □ M 2 💢 F	96 (In yrs. last	Yrs.	If Under 1 Your Months Da	ear If Under 24 Hr lys Hours Mir	n. (Month, L	irth Day, Year) 12,1920		olace (State or Foreign ntry) t Virginia
the Maryland 28a-f show	Director	10a. State 10b. County D. C.		10c. City, To	own or Lo	10f. Zip Coo	Washingto	on	10g. Citizen of		0d. Inside City Limits 1    Yes 2   No
3a or	Di		Street, N	T.7			20037				States
ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. It of Health and Mental Hygiene. or other treumatic event, It a Medical Evantiar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces?	Ever in U.S.		Was Decedent If Yes, specify (	of Hispanic Origin? Cuban, Mexican, Pue	(Specify Yes or Nerto Rican, etc.)		ce - Americ ck, White,	an Indian,
72 ho netur	Completed	15. Decedent's (Specify only highest		10	(Give	dent's Usual Oo kind of work do	one during most of w	orking	16b. Kind of B	usiness/ln	
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Hygie Hygie ther t		12 17. Father's Name (First, Middle, La	est)				Clerk 18. Mother's N	ame (First, Middi	le, Maiden Surnai	Rail:	road
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shound Mind Mind Mind Mind Mind Mind Mind Mi	-	19a. Informant's Name/Relationship			9b. Maili	ng Address (St	reet and Number or I				Code)
ges 1 and 2 t of Health a ff Item 27 is or other tre		Jean Post/ Sis 20a. Method of Disposition 11 Burial 2 □ Cremation 3		ceme	of Dispositery, crea	osition (Name of matory or other	place) Ser	Date	Californ 20c. Location		231 <u>1-3419</u> own, State
permit. Pages 1 and 2 Department of Health a Important: if Item 27 is eny injury or other trei		4 Donation 5 Other (Spe 21. Signature of Funeral Service Li	censee	Woods	B	2. Name and Ade ethesda	alPark 15	, 2006 obert A. ase, Inc	Pumphre 7557 V	, Wes y Fun Tiscon	t Virginia neral Home nsin Avenu
		23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused	d the death. D							Approximate Interval Between
Medicate be executed trificate be executed by physician and as the burial-transit	Aedical Examiner	resulting in death)  Society list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequent	ascu	xtremit lar Dis					
The law requires that the death certificate the state of the attending the attending page 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal dea	ath 3[	□Ectopic pregn □ Other <i>(specif</i> )				ite of delive	ery Day Year
quires tha on signed I uld be det	þ	Part II. Other significant condition	s contributing to death b	out not resultin	g in the u	nderlying cause	given in Part I.		I tobacco use con ] Yes 2 ∰ No		ne cause of death? eably 4 □Unknown
The law requir cate has been si page 2 should l	Completed							per	opsy formed?		psy findings available mpletion of cause of 2 No
sician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:				Other	eath Check only		·	
ding Phys h. After this funeral di	tion: To	1 ☐ Yes 2 ☒ No  27. Manner of Death  1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of Inju	ent 2□ER/ ury 28i uy Year)	Outpatier  b. Time of Injury	f 28c.	4 ₭ Nursing Injury at Work? 1 □ Yes 2 □ No		sidence 6 Oth how injury occur		y)
si or Atten i after deat I Director: d in by the	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place of In	jury - At home ic. (Specify)	, farm, st			28f. Location City or To	(Street and Numi own, State)	oer or Rura	d Route Number,
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai		Physician: To the best raminer: On the basis o and manner st	f examination							
To ti Withi To ti	Ž	29b. Signature and title of certifier	Tomon	Bro	, M		cense number	124	29d. Date signe	d (Month,	•
5		30. Name and address of person w Truong Bao, M.	D. 9715 Med	ical C	ente		#210 Roc	kville,	Maryland	208	50
Sta Regist OHMH 17 Rev 1/2		31. Date filed (Month, Day, Year)	32. Registr	rar's Signature		ache -					
			No.		ORIG	INAL					

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 29338 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** SEPTEMBER 05, 2006 Richard Baker 11:30P /Medical 4a. Sacility Name (If pot institution, give, street and number)
Saint Joseph Medical Center 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
May 7, 194 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1⊠M 2□F Months Hours unk 215-42-2845 62 1944 Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 27 ie marked other then "natural", or itama 23a or 28a-f ehow traumatic event, ine Madical Examinar must be nutified at 1 ☐ Yes 2X No Washington Hagerstown MD Direct 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? unk filed within 72 hours after death with 35 East Ave. P.O. Box 2632 21742 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. unk 1 Never Married 2 Marned ☐Yes 2 Yes, Give 2 🗆 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural", white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) unk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fitteen of Health and Mental Heart: If Item 27 le marked ott Be unk unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) St. Joseph Medical Center 7601 Osler Drive Towson, MD 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or 4 □ Donation 5 ☒ Other (Specify) in state 21. Signature of Funeral 22. Name and Address of Facility State Anato Baltimore, Anatomy Board more, MD 21201 655 W. Baltimore Street Ronald ector 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SHOCK Physician DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner RESPIRATORY FAILURE 2 DAYS S uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit RENAL FAILURE 1_DAY resulting in death) Last Due to (or as a consequence of): physician THROMBOCYTOPENIA DAYS by Physician/Medical use as the 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month detached for 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to complet in of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2V No 2 X No 1 Yes the funeral director. Be 25. Was case referred to medical 26. Place of Death | Check only on examiner' > No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ainpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 X Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred or Attending 5 Pending after death. investigation 1 Yes 2 No 3 🗌 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 THomicide within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

© Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10 D 0063974 MO 30. Name and address of pervin who completed cause of death (Item 231) (Type, Print) IMRAN SIDDIQI, M. D. OSLER DRIVE TOWSON, MARYLAND 21204 7601 32. Registrar's Signatu 31. Date filed (Month, Day, Year) SEP 1 5 2006 Registrar

		•	For State Registrar		State of Ma	aryland /	Depa / Depa	irtment of I tificate of	Health <i>Deat</i>	and Mo h	ental Hygi Re	ene20	06	29339
v .	Physici	an	1. Decedent's Name	e (First, Middle, Las rie Beeve							2. Date of Deati Sept 13,		Year	3. Time of Death 5:15AM M
	/Medic	al			street and number)			4b. City, Town,	or Location		тере 13,	4c. County	of Death	
4	y 3	38.0		ford Cour		,,		Carney	Millod	or 24 Hrs		Balt	imore	
1 - S.	Funeral ⁻ Director		5. Social Security N 198-16-	8066	M 2 XF	e (In yrs. last	3 Yrs.	If Under 1 Year Months Days		s Min.	8. Date of Birth (Month, Day, oug 5, 1			place (State or Foreign ntry) sylvania
	land ow		Usual Residence of 10a. State	10b. County		10c. City, T	own or Lo	cation					1	10d. Inside City Limits
	a-f sh	ctor	MD	Baltimor	e	Carne	ey							1 ☐ Yes 🎎 No
	vith the	Director	10e. Street and Nun					10f. Zip Code				g. Citizen of	What Cou	ntry?
	ne 23a	eral	27 Bide:	ford Cour	12. Was Decedent I	Ever in U.S.	13. \	21234 Was Decedent of f Yes, specify Cub	Hispanic (	Origin? (Spec				can Indian,
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Iteme 23a or 28a-f show aumatic event. I'm Medical Examinational be multibled at	Completed by Funeral	1 Never Marri	ed 2 Married 4 Divorced	Armed Forces? 1 ☐ Yes 2 👿 N If Yes, Give Year or Dates:	Мо		f Yes, specify Cub I□Yes 2♀ No			lican, etc.)	1	ck, White, by: Cau	_{etc.} Casian
S O	72 ho	eted	(Spec	15. Decedent's Ed		1	(Give	lent's Usual Occu kind of work done	during m	ost of workin	g	6b. Kind of B	usiness/In	dustry
2121	d within giene. er then	Compl	Elementary/Seco 12th gr		College (1-4or 5		Clerk	OO NOT use retire	ea)			TELEPH	ONE (	COMPANY
and	d be file ental Hy ked oth c event	To Be (	17. Father's Name (Camillo	(First, Middle, Last) D'Onofri	0					ther's Name y Gimo	(First, Middle, M ondi	faiden Sumai	пе)	
Maryland 21215-0036	nd 2 shoul Ith and Me 27 is mark	F	19a. Informant's Na	Beever,	ype, Print)			g Address <i>(Str</i> ee					State, Zip 234	Code)
Baltimore,	permit. Pagas 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or Iteme 23a or 28a-f show any injury or other traumatic event. It a Madical Examinating the richithed all once.				Removal from State	ceme	etery, cren	sition (Name of natory or other pla			ate 2	oc. Location	•	
Balti	permit. F Departm Importar any injui			neral Service Licen			22	<u>_</u>	ess of Fac	cility Mill	er-Dipp	el Fun	era1	Home, Inc. 21206
			23a. Part1 Enter the shock, or hea	ne disease, or comp rt failure. List only	ications that caused the cause on each lin	I the death. [	Do not ent	er the mode of dy	ing, such	as cardiac or	respiratory arre	st,	Tana	Approximate Interval Between
	Physician /Medical		Immediate Cause ( disease or condition resulting in death)	(Final in	a. 90	astron.	testin	al he	Nor	ha se				Onset and Death
37	Examiner				Due to (orals	a consequen	ice of);	·		Ü				•
	p #	ner	Sequentially list commany, leading to imcause. Enter Under	rlying	b. Dus to (or as	a consequen	ice of).							
	eath certificate ba executad attending physicien and for use as the burial-transit	Examiner	Cause (Disease or that initiated events resulting in death) is		c. Due to (or as	a consequen	ice of):							
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		Φ.	IF FEMALE:											
P.O. Box	The law requires that the death certif the has basn signsed by the attending page 2 should be detached for use a	Physician/M	23b. Was decedent in the past 12 1  Yes 2 9  Unknown	months?	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal de	ath 3	Ectopic pregnand Other (specify)	су			1	ite of delive onth	ery Day Year
	quires that the de n signad by the a uld be detached f	by	Part II. Other signif	icant conditions co	ontributing to death b	ar une	ng in fhe u	nderlying cause g	iven in Pai	rt I.	23e. Did tob	. /		he cause of death?
Division of Vital Records,	The law requirence has basen single 2 should l	Completed	Sel	eddem	a ICRE	ST si	ynder	4	<del></del>		24a. Was ar autopsy perform 1 Yes 2	ned 2	prior to co death?	opsy findings available impletion of cause of
/ital	cian: ertifica ector, p	Bec	25. Was case refer examiner?		4.5			10		ace of Death	Check only			
of	Physician: r this certificant and director.	To To	1 Yes 2 2	JNO _	28a. Date of Inju	ent 2□ER ry 28	Outpatien b. Time of	I 3L DOA		Nursing Hom	se 5 Aeside 8d. Describe ho	nce 6 Ott		(y)
ion	Attending in death.	atior	1 Accident	5 Pending investigation		y Year)	Injury		ork? ∃Yes 2	□No				
Divis	after de Directo	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injuding. et		, farm, str	eet, factory, office	)	2	8f. Location (Str City or Town	eet and Num. State)	ber or Rura	al Route Number,
	To the Hospital or Attending Physician: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier (Check out) one	1 Certifying Ph 2 Medical Exam	ysicien: To the best niner: On the basis of and manner sta	f examination	dge, death and/or in	n occurred at the t vestigation, in my	time, date opinion, d	and place, a leath occurre	nd due to the ca d at the time, da	use(s) and m ite and place,	anner as s and due to	stated. the cause(s)
	To the within 2 To the comple	M	29b. Signature and	title of certifier		4.0		29c. Licen	se numbe	or I C G	28	d. Date signe		
7	10		30. Name and addr	ess of person who	completed cause of d	leath (Item 23	3a) (Type	Print)	174	107		Sept	13,20	
	U		Dari	el Ley	MO G	10Fc	J-Ch	only St-	#5	lot	Tousan	M	2120	4
	Sta Regist		31. Date filed (Mon	un, Day, Year) SFP 1 5 21		ar's Signature	A	certi						

			1 - For State Registrar	ate of Maryland /	•	nt of Health and re of Death	Mental Hygiei	ZIIIIh	29340
	Dhuaisi		1. Decedent's Name (First, Middle, Last)				2. Date of Death	Day Year	3. Time of Death
Н	Physici /Medio		James Oscar	Cherry			8 3	6 2006	1446 M
	Examin	er	4a. Facility Name (If not institution, give stree Garret County) Ma			Town, or Location of Deat	h	4c. County of Deat	
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last		r 1 Year   If Under 24 Hrs		9. Birti	hplace (State or Foreign
	Director		207.304801 1AM	20F 72	Yrs. Months	Days Hours Min.			MD
	and and		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Location				10d. Inside City Limits
	ith with the Marylan 23a or 28e-f show ust be notified at	tor	MD Baltimon		heisters	toin			1 ☐ Yes 2 No
	h the	Director	10e. Street and Number		10f. Zij	Code	10g.	Citizen of What Co	untry?
			216 Conewood			91136		U.S.A	-
	ttems	Funeral	A. A.	Vas Decedent Ever in U.S. Imped Forces? MYes 2 ☐ No	13. Was Dece If Yes, spe	dent of Hispanic Origin? (S cify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White	
036	urs aft	þ		res, Give ear or Dates:	1 ☐ Yes	2D No Specify:		Specify: B/c	acc
1215-003	be filed within 72 hours after des tal Hygiene. d other then "netural", or tems event, ILe Medical Examination	Completed	15. Decedent's Education (Specify only highest grade con		6a. Decedent's Usu (Give kind of wo	al Occupation ork done during most of wo	rking 16b	Kind of Business/	Industry
121	within one. than	mpl		college (1-4or 5+)	life. DO NOT u	se retired)		M.T.A	
N	filed within I Hygiene.  Other than	e Co	17. Father's Name (First, Middle, Last)	years	11 00	18. Mother's Nar	me (First, Middle, Maid		
<u>a</u>	D 2 3 0	To Be	Stonewall Ch	uns		wil	o Ann		
Maryland	2 should and Men is marke eumatic		19a. Informant's Name/Relationship (Type, F	Print)	9b. Mailing Address	s (Street and Number or Ru			
	5 € Z =		20a. Method of Disposition	1e 30h Place	Le Canewa of Disposition (Na	ed Ave / Reis	Date 20c.	MD 31	136
Baltimore,	00		1 Burial 2 □Cremation 3 □Remo	val from State	etery, crematory or o	other place)			
E E	permit. Pag Depertment Important: I sny injury o once.		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee	dan	22. Name a	Cemetery Separated Address of acility	aughne. C	inestre	uneral Service
ñ	Ded in the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of		Naugh_ C. G.	~0	8725	I WATEL EAL	idallotum r		
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one care	ns that caused the death. Duse on each line.	o not enter the mo	A			Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as a consequence	ce of):				
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760,	icate be executed physicien and s the burial-transit		resulting in death) Last	Due to (or as a consequence	ce of):				
687	ficate p phys	edical	d						
ВОХ	eath certific ettending p I for use as	M/UE	230. Was decedent pregnant	yes, outcome of pregnancy □Live birth 2 □ Fetal dea		regnancy		23d. Date of deli	*
О.	The law requires that the death certific ste has been signed by the ettending p page 2 should be detached for use as	Physician/Me	1 Nes 2 No	Pregnant at time of death Unknown				Month	Day Year
<u> </u>	res that the de signed by the e I be detached f	/ Ph	Part II. Other significant conditions contribu	ting to death but not resulting	g in the underlying	cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
Records,	quires n sign ald be	d by					1 🗆 Yes	2 No 3 Pro	obably 4 []Unknown
O O	aw require as been sig 2 should b	Completed					24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
_	: The law cete has l , page 2 s	Som					performed	death?	2 No
Vital	ician: 1 certificet rector, p	Be	25. Was case referred to medical examiner?	tal:			ath (Check only one)		
6	Physician: r this certifice ral director, p	<u>۲</u>	115 Vez 5 140	1 Inpatient 21 EHV	Outpatient 3 Do	DA Other: 4 Nursing H 28c. Injury at Work?	lome 5 ☐ Residence 28d. Describe how in		eify)
<u>o</u>	nding ath. r: Afte e fune	atlor	Natural 5 Pending investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No		,,	
Division of	r Atte	Certification;	3 Suicide 6 Could not be determined 28	te. Place of Injury - At home, building, etc. (Specify)	, farm, street, factor	y, office	28f. Location (Street City or Town, St.	and Number or Ru ate)	ral Route Number,
<b>a</b>	pital c		29a. Certifier SCertifying Physicia	To the best of my knowled	den doeth convers			(-)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Medical	(Check only 2 Medical Examiner:	n: To the best of my knowled On the basis of examination and manner stated.	and/or investigation	i, in my opinion, death occu	e, and due to the cause urred at the time, date a	(s) and manner as ind place, and due	to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	A /	29	c. License number	29d. I	Date signed (Month	n, Day, Year)
	17		- Camillone	key h	~/>	U6430:	1 8	126 06	0
	10		30 Name and address of person who complete	oted cause of death (Item 23:	a) (Type, Print)	2 Fauth ?	street a	akland	MD 21550
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature		1 - Mill		-1	-
	Registr		SEP 1 5 2006	Ela usas So	A DENEL )				

			1 - For State Registrar	te of Maryland / De	eparti Certif	ment of He	ealth a		jiene 20(	06 29341
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  Florence Katherine	Culotta				2. Date of Dea Month Septemb	er 12, 2	Year 006 8:30 P M
	Examin		4a. Facility Name (If not institution, give street a		4b	b. City, Town, or		f Death	4c. County o	f Death
			Future Care Canton H		-d)	f Under 1 Year	If Under 2			N/A
	Funeral Director		5. Social Security Number 6. Sex 1 M 25	7. Age (In yrs. last birth) 93 Yr	M	donths Days	Hours	24 Hrs. 8. Date of Birth Min. (Month, Day March 1	0,1913	9. Birthplace (State or Foreign Country) Maryland
	/land		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location	ion				10d. Inside City Limits
	a-f sh	ctor	Maryland N/A			Baltim	ore			1 XYes 2 ☐ No
	or 28	Dire	10e. Street and Number		1	10f. Zip Code			log. Citizen of Wi	
	s 23e	eral	4900 E. Federal Stree	t Decedent Ever in U.S.	13 \//20		21205	nin? (Specify Yes or No-	U. S	- Anerican Indian,
36	should be filed within 72 hours after death with the Maryland Mahaller Hygene. Indiversely Hygene. In marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a ovent, the Modical Evanirar must be notified at	by Funeral Director	1 Never Married 2 Married 1	Yes 2 X No es, Give ir or Dates:			Specify:	gin? (Specify Yes or No- , Puerto Rican, etc.)	Black Specify:	White
9	2 hour	ted t	15. Decedent's Education	16a. D	ecedent	t's Usual Occupa	tion		16b. Kind of Bus	
215	thin 7. e. lan "n	Completed		lege (1-4or 5+)	ife. DO l	d of work done di NOT use retired)		of working	_	
2	iled wi tygien her th	Con	8th Grade  17. Father's Name (First, Middle, Last)			Waitr		r's Name (First, Middle,		taurant
Maryland 21215-0036	unid be fi Mental P arked of atic ever	To Be	Harry Diffenbaugh					Carrie Knor		,
lan,	2 sho and I Is ma rauma		19a. Informant's Name/Relationship (Type, Prin					r or Rural Route Number		
	1 and 2 Health ar iem 27 is other trau		Francis Culotta (Son) 20a, Method of Disposition			E. BALTA on (Name of ory or other place				ryland 21224 Dity or Town, State
ο̈́	Pages nent of I int: If It		1 X Burial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	from State Lorrai						re, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importanci If them 27 is marked other than "natural; or flems 23a or 28a-f show eny injury or other traumatic event, the Medical Evaninar must be notified at once.		21. Signature of Funeral Service Licensee	) maken	22. Na	ame and Address	s of Facility	Schimunek e, Baltimor	Funeral	Home Inc.
			23a. Part1. Enter the disease, or complications	that caused the death. Do no				_ <del>`</del>		Approximate Interval Between
2	Physician		shock, or heart failure. List only one caus Immediate Cause (Final disease or condition	Charles Obs	1.	chine Ry	Marian	A sust		Onset and Death
4	/Medical Examiner		resulting in death)	ue to (or as a consequence of	,,,	San San	,	17		
	_xammer	70	Sequentially list conditions, if any, leading to immediate	ue to (or as a consequence of)	toy	Prseus	2			
V	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
8760, -	cate be executed physician and the burial-transit	icai Exa		ue to (or as a consequence of)	);					
687	ificate g phys		d.							
Вох	th cert ending r use a	an/M	23b. was decedent pregnant	es, outcome of pregnancy Live birth 2 🗍 Fetal death	3 □Ect	topic pregnancy				of delivery
P.O. B	es that the death certific igned by the attending p be detached for use as	Physician/Med	in the past 12 months?	Pregnant at time of death Unknown		ther (specify)			Mont	h Day Year
	es that gned b	by PI	Part II. Other significant conditions contributing	. , , , , , , , , , , , , , , , , , , ,	he under	rlying cause give	n in Part I.			oute to the cause of death?
ord	w requir been si should	eted	Actic Stenders, H	1 Por yridans	·			1 U Y		Probably 4 Unknown
Records,	e la has	Completed				<del></del>		24a. Was a autops perform	med? pr	ere autopsy findings available for to completion of cause of eath?  Yes 2 No
Vital	Attending Physician: The death. sctor: After this certificate by the funeral director, pag	Bec	25. Was case referred to medical examiner?					of Death (Check only or		
of	Physi this c al dire	2	1 ☐ Yes 2 ☑ No Hospital  27. Manner of Death 28a.	I Inpatient 2 EN Outp		3 DOA Othe	4 1901	sing Home 5 Resid	ence 6 Other	
On	ding Ph lh. After th funeral	tion	1 Natural 5 Pending 2 Accident investigation	Date of Injury (Month, Day Year) 28b. Tir Inju	ury	28c, Injury Work' M 1 TY	? ′es 2 □ N		ow injury occurre	u
Division		Certification:	2 Cylinide 6 Could not be	Place of Injury - At home, farn building, etc. (Specify)	n, street,	, factory, office		28f. Location (S City or Town		or Rural Route Number,
۵	Hospital or 24 hours afte Funerat Dir tely filled in		29a. Certifier 1 Certifying Physicien:	To the best of my knowledge,	doath on	nourrod at the time	e date and	diplace, and due to the a	auso(o) and man	not no stated
	n 24 hc n 24 hc ne Fun	edicai	(Check only 2 Medical Exeminer: Or	the basis of examination and/ d manner stated.						
	To the within 2 To the complet	ž	29b. Signature and title of certifier	// //		29c. License				(Month, Day, Year)
				10 bo		100	6763	38	9/13/	06
	2		30. Name and address of person who complete	d cause of death (Item 23a) (T	ype, Prin	4 R. la	LARIN	e, MD2	1174	
	V/ Sta	ite	31. Date filed (Month, Day, Year)	32 Registrar's Signature	Angel	1	1 # 41/1	, lut	001	
	Registr	ar	SEP 1 5 2006	MANUAL AS P						

State of Maryland / Department of Health and Mental Hygiena For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Day Month 30 PN **Physician** Carpenter Septembel2 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death **Examiner** HARBORSIDE NURSING HOME BALTIMORE
If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 M XXF Yrs. Director 68 MARYLAND 214-38-6807 JULY Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County item 27 is marked other then "neturel", or items 23e or 28a-f show other traumatic event. The Medical Exercities must be notified at 1XXYes 2 ☐ No Director MARYLAND N/A BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2912 ULMAN AVENUE 21217 U.S.A. Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene. Int: If Item 27 is marked other then "neturel", or Items 23 Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) llth Grade HOUSEWIFE N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 EDWARD MANNS PAULINE MANNS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James B. Carpenter/Husband 2912 Ulman Ave., Baltimore, Maryland 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition tal 2 ☐ Cremation 3 ☐ Removal from State 0 Department of Importent: if any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 09-14-06 OWINGS MILLS, MARYLAND 21. Signature of F 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ENCEPHALOPATHY Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Universe of Impury that initiated events Due to (or as a consequence of): Examiner sician and burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physiclan/Medlcal use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) been signed to should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ρ 1 Yes 2 No 3 Probably 4 Whiknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 2 No 1 ☐ Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one examiner Cther: 4 Thursing Home 5 Residence 6 Other (Specify) Certification: To 1 🔲 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural Injury 5 Pending 1 Yes 2 🗌 No investigation 2 Accident , after death I Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours To the Funerel 29a. Certifiei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical tely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier SEPTEMBER 12, 2006 00060560 propeted cause of death (Item 23a) (Type, Print) 30. Name and address of person and NECK RD- \$109 BALTIMORE, MD PANKAS KHETERPAL 201, BAYLRIVER 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 5 2006 Registrar

		1	For Amend item#20a-c	State of Mar perFH,0859;	dand/Der	partment of ertificate of	Health f Death	and Mental I	Hygiene	2006	29343
	Physici		1. Decedent's Name (First, Middle, Last)					2. Date of Month	Day	2006	3. Time of Death
4	/Medio Examin		4a. Facility Name (If not institution, give	1 - 1		4b. City, Town	, or Location			County of Deat	
			5. Social Security Number 6. Sex	7. Age (1	n yrs. last birthda	D2 10	YMOY I	r 24 Hrs. 8. Date of	Birth	N/A 9. Birt	hplace (State or Foreign
	Funeral Director			M 2□F	75 Yrs.	Months Day	s Hours	Min. (Month	Day, Year)	, Co	RYLAND
	and w.		Usual Residence of Decedent  10a. State 10b. County	10	Oc. City, Town or	Location					10d. Inside City Limits
	Maryl	tor	MARYLAND N/A		BALT	'IMORE					1)X Yes 2 ☐ No
	or 28s	Director	10e. Street and Number			10f. Zip Code			10g. Citi	zen of What Co	untry?
	ath w	lal	2210 BAKER STREE			N/a- Dandan	21216			U.S.A.	rican Indian
36	hours after death with the Maryland lursi; or Iteme 23e or 28e-f show at Expressional be notified at	by Funeral	11. Maritat Status  1 Never Married 2 Married  3 Widowed 4 Divorced	<ol> <li>Was Decedent Eve Armed Forces?</li> <li>1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:</li> </ol>	erin U.S.	If Yes, specify Co		rigin? (Specify Yes o an, Puerto Rican, etc. v:	)	Black, White	e, etc.
Maryland 21215-0036	72	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) Cotlege (1-4or 5+)	(Gi	cedent's Usuat Occ ve kind of work dor DO NOT use reti	ne durina mo	st of working	16b. Ki	nd of Business/	Industry
121	filed within Hygiene. other then		12th grade		BE	SAUTICIAN	18. Moth	ner's Name (First, Mic		OSMETOL Sumame)	OGY
anc	2 2 2 2 S	To Be	OLIVER CONWAY					THEL CONWA		00	
ary	s 1 and 2 should I I Health and Meni Item 27 is marka other traumatic	-	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Ma	iling Address (Stre	et and Numb	ber or Rural Route No	ımber, City o	r Town, State, 2	Zip Code)
≥, ₹	1 and 2 Health em 27 i		Travis Johnson/Fri				St., E	Baltimore,		and 212 cation - City or	
Jore	6 O - L		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Re		New Cath	position (Name of rematory or other c ediral Cemet			Ba1	timore.	
Baltimore,	permit. Page Department ( Important: If any injury or once.		4 Donation 5 Other (Specify) 21. Signature Funeral Service License		Mr. 210	ON CEMETE  22. Name and Add  WILLIAM	iress of Faci	09-15-06  N COMMUNI			MARYLAND ME P.A.
	20 E E G		23a. Part1. Enter the disease, or comptic	rations that caused th	e death. Do not e	1206 W N	ORTH A	VENUE			Approximate
	Physician /Medical		shock, or heart failure. List only on Immediate Cause (Final disease or condition resutting in death)	cause on each line.	y zrteny	disease	iying, such a	s cardiac or respirate			Interval Between Onset and Death
H	Examiner			Due to (or as a o	onsequence of):						
	D ==	ner	Sequentially list conditions, if any, leading to infriedrate cause. Enter Underlying	Due to (or as a c	onsequence of):						
	be executed sicien and burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a o	consequence of):						
68760,	cate be ex physicien a the burial	calE	۵								
89	ing phy as th		IF FEMALE:								
.О. Вох	t the death certificate be executed by the ettending physicien and lached for use as the buriat-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	Sc. tf yes, outcome of 1 Live birth 2 l 4 Pregnant at tin 9 Unknown	Fetal death	3□Ectopic pregna 5□ Other (specify)			_	23d. Date of del Month	ivery Day Year
<u>α</u>	signed d be del	<u>م</u>	Part It. Other significant conditions con HIV, ESRD, Bahn	tributing to death but in		underlying cause	given in Part		Did tobacco u		o the cause of death?
of Vital Records,	The law requisite has been page 2 should	Completed							Mas an autopsy performed?	prior to death?	utopsy findings available completion of cause of 2 No
/ita	Physician: Tribis certificerral director, p	Be	25. Was case referred to medical examiner?	annitals \d				ce of Death (Check of	nly one)		
of	<b>8</b> .∞ ₹	-: To	1 Yes 2 No	ospital: 1 Inpatient 28a. Date of Injury	2 ER/Outpat	ient 3L DOA	Other: 4 1 N njury at Vork?	Nursing Home 5 1 28d. Desc	Residence ribe how injur		cify)
ion	Attending or death.	atlor	1 Accident 5 ☐ Pending investigation	(Month, Day Y	'e <i>ar)</i> In <del>i</del> ur		Vork? ☐Yes 2[	□No			
Division	or Attend after death Director: ,	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	- At home, farm, (Specify)	street, factory, office	СӨ		on (Street an r Town, State		ural Route Number,
_	To the Hospitel or Attending Ph within Z4 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C		ician: To the best of eler: On the basis of eler and manner state	kamination and/or						
	To th Withir To th comp	Me	29b. Signature and title of certifier			29c. Lice	ense number	r		te signed (Moni	
) ,	4		Ludvit A	< MO			393		Sept	ember 9	2006
7	,		30. Name and address of person who co	St Balti	more, 1	oe, Print) MD 2 12	36				
	St Regist	ate rar	31. Date filed (Month, Day, Year) SEP 1 5 2	32. Registrar	s Signature	Cook					

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ORIGINAL

			For State Registrar	State of Ma	,	epartme Certifica			and M		Reg. No.	4 U U b	29344
ě	Physici	an	Decedent's Name (First, Middle		<b></b>					2. Date of De Month	Day		3. Time of Death
	/Medic	410	4a. Facility Name (If not institution,	GRACE CAR	TER	4b. Cit	y, Town, or	Location o	of Death	JUL 4		County of Dea	4:05 A
***	Examin	er	NATIONAL NAVAL		TFD		BETH					MONTGO	
	Funeral	20, 24	5. Social Security Number	6. Sex 7. Ag	e (In yrs. last birth		er 1 Year	If Under		8. Date of Bird	h Vearl	9. Bir	thplace (State or Foreign
	Director		N/A	1 □ M 2 🛣 F	Y	rs. Month	s Days	Hours	Min. 87	(Month, Da			MARYLAND
	P .		Usual Residence of Decedent  10a, State 10b, County		10c, City, Town	or Location							10d. Inside City Limits
	anyia shov	2		E WILLIAM	Toc. Oity, Town	DUMF	RTFC						1 TYYes 2 □ No
	the M	Director	10e. Street and Number	O WEDDER			ip Code				10g Citi	zen of What C	21
	with the same		4218 LAMAURIC	TE TOOD			220	? E					,
	death	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was Dec			gin? (Spe	cify Yes or No Rican, etc.)		CED STA 14. Race - Am	encan Indian,
9	or ite		1 XNever Married 2 Marri	Armed Forces?	No		••	n, Mexican Specify:	i, Puerto i	Rican, etc.)		Black, Whi	
9	ours real', c	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 105	2121110	эрвспу.				Specify:	BLACK
1215-003	J within 72 hours after death with the Maryland jiana. Tahan "natural", or items 23a or 28a-f show Ira Mazilcal Examinan mast be mulified at	Completed	15. Decedent (Specify only highes	's Education t grade completed)		Decedent's Us (Give kind of v life, DO NOT	vork done d	urina mosi	t of workir	ng	16b. Ki	nd of Business	/Industry
2	within ane. then	dmo	Elementary/Secondary (0-12)	Coltege (1-4or 5	5+)	III. DO NOT							
2	e filed of her vent,	e Co	17. Father's Name (First, Middle,	Last)			N/A	18. Mothe	r's Name	(First, Middle,	Maiden	Sumame)	
an	should be nd Mental marked c matic ev	To B	DAVID ALLEN CAL	RTER				JESS	ICA :	MONIQUE	: нот	MES	
Maryland 21	2 shou and N is mar sumat	-	19a. Informant's Name/Relationsh		19b.	Mailing Addre	ss (Street a					r Town, State,	Zip Code)
Σ.	s 1 and 2 if Health item 27 i		JESSICA CARTER	MOTHER		18 LAM		IE LO		DUMFRI			
ore	of H of H r ite		20a. Method of Disposition  1 D Burial 2 Cremation	3 Removal from State	20b. Place of cemetery	Disposition (N v, crematory o	ame of other place	9)		ate		cation - City or	
altimore,	permit. Pag Department Important: any injury once.		4 □ Donation 5 □ Other (S)  21. Signature of ¶uneral Service J		NAME	Berttesd	and Addres			6-06	Beri	HESDA M	10
Ba	permit. Pag Department Important: f any injury o		<b>)</b> / /	11.1		NAME							
\$			23a. Parvi. Enter the disease, or shock, or heart failure. List	complications that caused	the death. Do n					r respiratory a	rest,		Approximate
	Physician		Immediate Cause (Final										Interval Between Onset and Death
12	/Medical		disease or condition resulting in death)		XTREME P a consequence o		RITY					_	
Sept.	Examiner		Sequentially list conditions.	b									
	sit 9d	lner	Sequentially list conditions, if any, leading to him edials cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence o	f):							
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Ó	tificate ig phys as the	ਰ				-					- pe		
Вох	eath certific attending pi	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Fetal death	3 Ectopic	pregnancy				1	23d. Date of de	
	The law requires that the death certific ite has been signed by the attending p page 2 should be detached for use as:	Physician/Me	in the past 12 months? 1 Yes 2 No	4☐Pregnant at 9☐Unknown		5 Other						Month	Day Year
о. О	that the de ed by the a detached	Phy	9 ☐ Unknown  Part II. Other significant condition	and contribution to double	ust not socialize in	the underhine		n in Dort I		23a Did t	obacco u	eo contributo t	o the cause of death?
S,	ires tha signed d be de	l by	ran ii. Other significant condition	are commoding to death b	at not resulting in	the didenying	cause give	minirali.			/es 2[		robably 4 Dunknown
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Record	has has ge 2 s	Completed								24a. Was autor perfo	an osy rmed?	prior to death?	utopsy findings available completion of cause of
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Vita	ysician: ns certifica director, j	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 💹 No	Hospital: 1X Inpatie	ent 2 ER/Out	patient 3	Othe	-		(Check only o		6 □Other (Spe	aciful
ō	y Phy er this	7: To	27. Manner of Death	28a. Date of Inju	ıry 28b. T	ime of	28c. Injury Work			28d. Describe			ony)
<u>o</u>	Attending Physician: r death. ector: After this certific. by the funeral director.	atio	1 Natural 5 ☐ Pendin 2 ☐ Accident investig		y rear) ir	ijury M		/es 2 🗌	No				
Division of	f or Attendation after deati	Certification:	3 ☐ Suicide 6 ☐ Could in determined	inod 289. Flace 01 III	jury - At home, far	m, street, fact	ory, office		2	28f. Location (: City or To			lural Route Number,
	ital o irs aft ral Di												
	24 hours 2 Funeral etely filled	edical		g Physician: To the best Examiner: On the basis of and manner st	f examination and								
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	Mec	29b. Signature and title of certifie			4	29c. License	number			29d. Dat	e signed (Mon	th, Day, Year)
)	->-0		> Bush B	Dur Vm 9	het		01012	23923	9 (V	A)	Ji	116	, 300R
			30. Name and address of person	who completed cause of o	death (Item 23a) (	Type, Print)	N.A	ATION	AL N	AVAL ME	DICA	L CENT	ER
			BRYAN BOUCHER	CPT MC US			ВІ	ETHES	DA M	20889	-560	0	
	Sta Regist	ate	31. Date filed (Month, Day, Year)	5 2006 32. Polisto	rar's Signature	The sale	0-						

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registra 29345 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year Physician ANGEL CARTER JUN 30 2006 3:45 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER **BETHESDA** MONTGOMERY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 🔀 F Director N/A JUN 30 2006 MARYLAND Usual Residence of Decedent the Maryland 10b. County 10c, City, Town or Location 10a. State 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 ☐ No Directo VIRGINIA PRINCE WILLIAM DUMFRIES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö "natural", or Itams 23a 4218 LAMAURICIE LOOP 22025 UNITED STATES 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic evant, the Medical Examina 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DAVID ALLEN CARTER JESSICA MONIQUE HOLMES ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JESSICA CARTER/MOTHER 4218 LAMAURICIE LOOP DUMFRIES VA 22025 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-16-04 BetHesda Mo NNMC BETHEED 21. Signature of Funeral Service Licenses 22. Name and Address of Facility ooney ama NAME BETHESDA MO Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** EXTREME PREMATURITY /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1□ Yes 2😿 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After 1 X Natural 5 Pending М 1 Yes 2 No death. investigation after death 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral Hospital 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0101239239 (VA) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER BRYAN BOUCHER CPT MC USA BETHESDA MD 20889-5600 31. Date filed (Month Day SEP) T'5 2006 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Registrar

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SEPTEMBER

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		í	1 - For State Registrar	State of N	Maryland	d / Depa <i>Cei</i>	artment of H rtificate of L	lealth a D <i>eath</i>	ınd Men	ntal Hyg	iene 2001	5 29347		
	Dhyoisi		1. Decedent's Name (First, Middle,	ast)						Date of Death Month	h Day Ye	3. Time of Death		
	Physici /Medic		William Ha						S		per 10, 20	06 8:12A M		
	Examin	er	4a. Facility Name (If not institution, g		er)		4b. City, Town, or		f Death		4c. County of D			
		¥	21512 Rippleme 5. Social Security Number 6		Age (In yrs. la	ast birthday)	Laytonsv		24 Hrs.   8 (	Date of Birth	Birth 9. Birthplace (State or Foreign			
	Funeral Director		250-64-4692	1 <b>X</b> M 2□ F	67		Months Days	Hours	Min. (	Month, Day,	, 1939 Ma	Country)		
	7		Usual Residence of Decedent							20	, 1737 110			
	show	_	10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2 ☑ No		
	8a-f	Director	Mayland Montgo	mery	Lay	tonsv								
	with t	급	10e. Street and Number	1 7			10f. Zip Code				0g. Citizen of What			
	ns 23	eral	21512 Ripplemea	d Drive	nt Ever in U.S	3. 13. \	20882 Was Decedent of Hi	ispanic Orig	in? (Specify		United St	ates merican Indian,		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any futury or other traumatic event, the Machel Exemple must be notilised at angle.	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces  1 X Yes 2 C  If Yes, Give  Year or Dates	No		f Yes, specify Cuba 1 ☐ Yes 2🎇 No	n, Mexican,	, Puerto Rica	in, etc.)	Black, W			
Ö	72 hor	Completed	15. Decedent's (Specify only highest	Education		16a. Deced	dent's Usual Occupa	ation	of working	1	16b. Kind of Busine			
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7	led w tygier her th		12. Father's Name (First, Middle, La			Faci	lity Supe				Bank			
anc	ntal H	Be		Sij							Maiden Sumame)			
Ž	should of Me mark matic	은	William Dove  19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	ng Address (Street a			D. Co	ooper City or Town, Stat	? Zin Code)		
<u>8</u>	ith ar 27 is r trau		Anita Lawless D				277763					Maryland 20882		
ltimore,	s 1 ar		20a. Method of Disposition	-707	20b. Pla	ace of Dispo	sition (Name of natory or other place Wn	a) C	eptemb	- 9	20c. Location - City			
Ē	Page nent o int: If		1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		te Fore	est La ory Ga	wn rdens	າ ເວັດ 11:	8, 200	. 1	Greenwood	Indiana		
a	rmit. porta porta y Inju		21. Signature of Duneral Service Lice	ensee	1220	22	. Name and Addres	s of Facility	Rober	+ A. T	Pumphrev	Funeral Home/		
<u> </u>	99 5 5 9		1 Abili	Elem	M00	803 R	ockville,	Mary	300 W land	lest Mo 20850-	ontgomery -2805	Avenue		
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that causely one cause on each	ed the death. line.	. Do not ent	er the mode of dying	g, such as c	cardiac or res	spiratory arre	est,	Approximate Interval Between		
32%	Physician		Immediate Cause (Final disease or condition resulting in death)	_a_ Metas	tatic	Colon-	-Rectal C	ancer				Onset and Death  2 vrs. 2 mos.		
4	/Medical Examiner		resulting in death)	Due to (or a	as a consequ	ence of):								
2		-	Sequentially list conditions, if any, leading to immediate	b. Liver	Failu	ence of):						Approx. 1wk.		
/	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	,		,								
/ <u>,</u>	exec an an rial-tr		resulting in death) Last	Due to (or a	as a consequ	ence of):				<del>-</del>				
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Ö	artifica ing pt	Med	IF FEMALE:											
Вох	leeth certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1☐Live birth	2 Fetal	death 3	Ectopic pregnancy				23d. Date of Month	delivery Day Year		
0	he de the s	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown		ath 5∟	Other (specify)							
0	res that the de signed by the a be detached f		Part II. Other significant conditions	s contributing to death	but not resu	Iting in the ur	nderlying cause give	en in Part I.		23e. Did tob	acco use contribute	lo the cause of death?		
ds	puires n sign ald be	d by								1 🗆 Ye	s 2 No 3	Probably 4 DUnknown		
Ö	sw require s been si	Completed								24a. Was ar	24b. Were	autopsy findings available		
æ	The la	ШО								autopsy perform 1 Yes 2	ned? death			
ä	sician: The law certificate has l irector, page 2 s	Bec	25. Was case referred to medical examiner?					26. Place		neck only one		-		
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Division of Vital Records,	ding Ph h. After th funeral	iuo!	27. Manner of Death 1	28a. Date of In (Month, D	njury Day Year)	28b. Time of Injury	Work		1	Describe hor	w injury occurred			
Sic	death death stor: , the f	Icat	2 Accident investigat 3 Suicide 6 Could not	be Georgia	Injuny - At hor	mo form etc	M 1 1	Yes 2 □ N		Location (Str	and Alumbar or	Rural Route Number,		
<u>&gt;</u>	pital or Atten ours after deat leral Director: filled in by the	Certification:	4 Homicide determine	building,	etc. (Specify)	)	eet, factory, office		201. 1	City or Town,	, State)	Aurai Aoute Number,		
	To the Hospital or Attending Physician: which 24 hours after death as a fire death is certified to the Funeral Director. After the conflict completely filled in by the funeral director.	edical C	29a. Certifier (Check only one)  1 Certifying 2 Medical Ex	Physician: To the best aminer: On the basis and manner:	of examinati	vledge, death ion and/or inv	occurred at the time vestigation, in my op	ne, date and pinion, death	place, and on the occurred at	due to the ca t the time, da	use(s) and manner ite and place, and c	as stated. lue to the cause(s)		
	To the Hos within 24 h To the Fun completely	Me	29b. Signature and title of certifier	0			29c. License	e number		29	d. Date signed (Mo	onth, Day, Year)		
			<b>H</b> —	W9/			010123	39089			9/11/0	6		
	10 X1		30. Name and address of person wh	io completed cause of	f death (Item	23a) (Type,					• •			
	ı		Dennis Dobrzynsl	ci, M.D.	5226 D	awes A	venue, A	1exanc	dria,	Virgin	ia 2231	1-1404		
	Sta Registr	_	31. Date filed (Month, Day, Year) SEP 1 5	2006 32. Figure	strar's Signati	de s	raile							

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	Physici		Decedent's Name (First, Middle, Last)  ELIZABETH DAV	IS				2. Date of Dea		Year O6	3. Time of Death
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give street  5. Social Security Number  6. Sex  1 M 2	T. Age (In yrs	SODIE S. last birtho	(ay) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da FEB 4	4c. County h y, Year) 1920	of Death	lace (State or Foreign http:// RYLAND
	ow II		Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town o	r Location		-		1	Od. Inside City Limits
2	death with the Maryland ma 23a or 28a-f ahow r nuat be nytified at	Director	MARYLAND BALTIMORE  10e. Street and Number			BALTIMORE 10f. Zip Code			10 - 0'''	45. 10	1 □ Yes 2XXVo
THE CHE	23a or	ral Dir	3 LIBRA CT.			212	237		10g. Citizen of U.S.		ntry ?
2017 036	after or Ite	by Funeral	1 Never Married 2 Married 1	as Decedent Ever in I ned Forces? ]Yes 2 []No ∕es, Give ar or Dates:	U.S.	13. Was Decedent of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interpretation of Interp	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Rad Bla Specif	e - Ameno ck, White, /: BLA	etc.
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5, and 21	be filed stal Hygid od other avant, I	Be	unknown 17. Father's Name (First, Middle, Last)			DOMESTIC	18. Mother's Nam		SEI Maiden Suman		
Maryland	s 1 and 2 should f Heelth and Men fam 27 la marke other traumatic	ဥ	JOSEPH WEEDEN  19a. Informant's Name/Relationship (Type, Pr	int)	19b. M	failing Address (Street		WEEDEN	r, City or Town,	State, Zip	Code)
	1 and 2 Heelth a am 27 is		Russell E. Davis/Sc		Place of D	362 Fontana isposition (Name of		ltimore, Date	Maryla		
Baltimore,	permit. Pages 1 and 2 Department of Heelth a Important: If Itam 27 is any Injury or other tra ance.		NXBurial 2 ☐ Cremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify)	al from State	cemetery,	orematory or other place ON FOREST	09-1	3-2006			S, MARYLAND
Ba	Depermit Depermit Impor		21. Signature of Funeral Pervice Licentels			22. Name and Addre WILLIAM C 1206 W NOI	BROWN COI		FUNERAI	HOM:	E P.A.
•	Physician /Medical Examiner			Se on each line.  Oue to (or as a conse	equence of)		The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s		rest,		Approximate Interval Between Onset and Death
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Division of Vital Records, P.O. Box 68	Attanding Physician: The law requires thet the death certificate cleath. setor: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the	Physician/Medic	in the past 12 months?	res, outcome of pregr ]Live birth 2 ∏ Fet ]Pregnant at time of ]Unknown	tal death	3 □Ectopic pregnancy 5 □ Other (specify) _	,			te of delive	ory Day Year
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Į Vit	nysician nis certif director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospita	l: 1 ☐ Inpatient 2 Ç	ZEP/Outpa	atient 3 DOA Oth	26. Place of Deat			er (Specify	()
sion o	ttanding Ph Jeath. tor: After thi the funeral	Certification:	1 Natural 5 Pending 2 Accident investigation	. Date of Injury (Month, Day Year)	28b. Tim Inju	ry Woi	yat k? Yes 2 □ No	28d. Describe h			
Divi	Ital or Attandi rs effer death. at Director: A led in by the fu	Certif	4 Homicide determined	building, etc. (Spec	cify)	, street, factory, office		City or Tow	n, State)		l Route Number,
	To the Hospital or A within 24 hours effer To the Funeral Direct completely filled in by	Medical	29a Certifier 11 Certifying Physician (Check only one) Medical Examiner: O al	To the best of my lim n the basis of examin nd manner stated.	newladge d nation and/o	eath occurred at the fir or investigation, in my o	rie, date and place pinion, death occur	and due to the cred at the time, o	date and place,	and due to	the cause(s)
	To the within to the comp	W	29b. Signature and fittle of certifier			29c. Licens	e number 54725		29d. Date signe	d (Month,	Day, Year)
	2		DP. JOSE 10287	ed cause of death (Ite			:de Bo	x H mo	RE. 1	10	21227
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2006 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10 2006 EVANS 3:40 September /Medical 4a. Facility Name (If not institution, give street and number)

Mercy Medical Ceu 4b. City, Town, or Location of Death 4c. County of Death Examiner faltimore If Under 1 Year If Under 24 Hrs. 6. Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 F Months 214-62-716 Usual Residence of Decedent Director March filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State show rthan "natural", or itema 23a or 28a-f shoving Medical Examinar must be notified at 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funerai 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Be Completed by Year or Dates: 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO, NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygies Important: if item 27 is marked other it any injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Sumame oma 19a. Informant's Name/Relationship (Type, Print) Laughter 19b. Mailing Address (Street and Number or Rural Rou e Number, City or Town, State, Zb Code) ower Baltimore, Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Pemoval from State 4 Donation 5 Other (Specify) 22. Name and Address of 21. Signature of Funeral Service Licensee Enter the disease, or complications that caused the for heart failule. List only one cause on each line. caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock for heart failu Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a con-Examiner Turumodeficiency Syndrone Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Hepatikis C 2 No 3 Probably 4 □Unknown Completed End Stage leval Msease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 No To the Hospital or Attending Physicien: within 24 hours after death.
To the Funerel Director: After this cartific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ۵ 1 Impatient 2 ER/Outpatient 3□ DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Sept. 10, 2006 DS6399 completed cause of death (Item 23a) (Type, Print)
MD 301 ST. RWL ST. Baltinere, MD 21201 32. Pagistrar's Signature 31. Date filed (Month, Day, Year) State SEP 1 5 2006 Registrar

			For State Registrar	State of Maryl	and / Depa	artment of I	lealth and <i>Death</i>		ene2006 g. No.	29350		
	Physicia	an	1. Decedent's Name (First, Middle, Las				-	2. Date of Death Month	Day 13, 2000	3. Time of Death 9:39 P M		
	/Medic	al .	Adele M. Fie 4a. Facility Name (If not institution, give			4b. City. Town.	or Location of Dea		4c. County of Deat			
	Examin	er	Catered Living o				l Air		Harfor	d		
	Funeral Director		5. Social Security Number 6. Se 215-90-8056	90 7. Age (In	yrs. last birthday) Yrs.	If Under 1 Year Months Days		S. 8. Date of Birth (Month, Day, April 1,	Year 1916 Mar	hplace (State or Foreign untry) YLand		
	pue *		Usual Residence of Decedent  10a. State 10b. County	10c	. City, Town or Lo	ocation				10d. Inside City Limits		
	Maryl	to	Maryland Harford			Bel Ai	r			1 ⊠Yes 2 □ No		
	or 28,	Director	10e. Street and Number 1415 St. Francis	Donal		10f. Zip Code	0101		g. Citizen of What Co	untry?		
	eeth w	Funeral	14 15 St. Frances	12. Was Decedent Ever	in U.S. 13.	Was Decedent of	2101		U.S.A.	ncan Indian,		
39	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylend Department of health and Mental Hygiene. Department of health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ing Medical Exercit at must be notified at ance.	by Fun	1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates:	i	If Yes, specify Cub 1 ☐ Yes 2 ☐ No		(Specify Yes or No- erto Rican, etc.)		Black, White, etc.		
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/lan	Mental Parkad of	ToB	Elmer Abels				Mart					
Maryland 21215-0036	12 sho h and 7 ie mu trauma		19a. Informant's Name/Relationship (1)  Marti McCammon	Type, Print) (daughter				Rural Route Number, rest Hill,	City or Town, State, AMD 2105	_		
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Baltimore,	permit. Departr importu eny inji		21. Signature of Funeral Service Licen	•	3	2. Name and Addr Chimunek 10 W. Ma	ess of Facility Funeral cPhail R	Home of 1	Bel Air, I ir, MD 210	nc. 14		
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the one cause on each line.	death. Do not en	ter the mode of dy	ing, such as cardi	ac or respiratory arre	st,	Approximate Interval Between Onset and Death		
	Physician /Medical		fmmediate Cause (Finaf disease or condition resulting in death)	.a/\(\begin{array}{cccccccccccccccccccccccccccccccccccc	onsmall	cell	lung C	cencer		2 months		
В	Examiner		200	540 10 (0) 43 4 000	risequence or);		O					
	р <u>#</u>	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (ur as a cul								
√_	and al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cor	nsequence of):							
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89	artificating phone	Medi	IF FEMALE:									
Вох	attend for us	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pr 1 Live birth 2 4 Pregnant at time	Fetaf death 3	□Ectopic pregnan	су		23d. Date of de Month	Day Year		
P. O.	by the	hysle	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown				1414	AEC-300			
Vital Records, P	The law requires that the death certificate be executed sie has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	ρ	Part If. Other significant conditions of	ontributing to death but no	t resulting in the	underlying cause g	iven in Part I.		acco use contribute t s 2 ☐ No 3 ☐ P	o the cause of death?  robably 4 Unknown		
eco	2 8 8	Completed						24a. Was ar	prior to	utopsy findings available completion of cause of		
a B									No 1 ☐ Yes	2 □ No		
ZE S	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ fnpatient	2 🗆 ER/Outpatie	ent 3 DOA D	thor	Death (Check only one Home 5 ☐ Reside	nce 6 Other (Spe	Assisted		
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Division of	efter of Direction by	Certification:	4 Homicide determined	28e. Place of Injury - building, etc. (S		reer, ractory, omce	•	City or Town		arar noute Namber,		
	To the Hospital or Attending Phymhin 24 hours effer death. To the Funeral Director: After the completely filled in by the funeral	Medical C	29a. Certifier 17 Certifying Pt (Check only 2 Medical Exar one)	nysician: To the best of my niner: On the basis of exa and manner stated.	y knowledge, dea mination and/or i	ith occurred at the nvestigation, in my	time, date and pla opinion, death or	ace, and due to the ca courred at the time, da	use(s) and manner a ate and place, and du	s stated. e to the cause(s)		
	To the within 2 To the comple	Me	29b. Signature and title of certifier	- 112		29c. Licer	nse number	, 29	ed. Date signed (Mon			
	3		30. Name and address of person who	completed cause of death	(Item 23a) (Type	p, Print)	s, ib an	s Rolto	/			
		ate	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	K)		a Dario,	UD 212	~ '		
	Regist	rar	SEP 1 5 2006	FIREWAY S	- All services	V HOSP						

			For State Registrar	State of Maryland		artment of I		Mental Hy	ygiene Reg. No	2006	29352	
			Decedent's Name (First, Middle, Last)					2. Date of D	eath		3. Time of Death	
	Physicia /Medic		Joseph M	. Falb	)			Septem	Der 12		6: 52 PM	
	Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town,	or Location of Dea	ath	4c.	. County of Death	1	
			Union Memorial Hosp				ore City			N/A	10.	
	Funeral Director		5. Social Security Number 6. Sex 19−30−7415	M 2□ F 7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days			Day, Year)	Col	place (State or Foreign intry) vland	
			Usuel Residence of Decedent									
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e Ma	A Series	Director	Maryland Baltimore	9	Dunda	·						
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urs aft	"neturel", or items 23e or 28e-f ehov edicel Exentral must be notified at	þ	1 Never Married 2X Married 3 Widowed 4 Divorced	1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:			Specify: Who	ite	
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thin 7	. Pag	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)			during most of ward)	orang				
1 2	ygien t, the	S	12 years		Mec	hanic				utomotiv	<i>r</i> e	
Should be filled within 72 hours after death with the Maryland	ed oth	Be.	17. Father's Name (First, Middle, Last)  Alex Falbo					ame (First, Midd. Bonni.co)		Sumame)		
houle	d Me mark matic	ဥ	19a. Informant's Name/Relationship (Typ	e. Print)	19b. Mailir	ng Address (Stree	t and Number or F			or Town, State, Z	ip Code)	
8 2 2	ith and 27 to treu		Ann Falbo	Wife	217,	Patapso	o Avenue	, Dunda	lk, M	aryland	21222	
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	Department of Health and Mental Hygiene. important: if Item 27 ie marked other then "natueny injury or other treumatic event, the Medical pace.		21. Signature of Fundal Service License	C. Cm	nedla	Name and Addr Opnelly 110 Soll	ess of Facility Funeral ers Poin	Home Of	Dund	alk,P.A.	21222	
			23a. Part . Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death.	Do not ent	er the mode of dy	ing, such as cardi	ac or respiratory	arrest,	CITIC CID.	Approximate Interval Between	
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	/Medical		resulting in death)	Due to (or as a consequ							300.73	
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5	÷	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ADREC dis							not known	
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9	ohysician and the burial-transit	dical E	L.									
o di	g phy as the	edic										
5 8	esn .	M/W	23b. Was decedent pregnant	ac. If yes, outcome of pregnar		Ectopic pregnanc	cv			23d. Date of deli		
9 6	been signed by the attending p should be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of de 9☐ Unknown		Other (specify)	-,			Month	Day Year	
r tad	ad by detacl		Part II. Other significant conditions conf	tributing to death but not resu	lting in the u	nderiving cause g	iven in Part I.	23e. Dic	d tobacco	use contribute to	the cause of death?	
נים לי	signe ld be	ompleted by	Cosonary arter					10	Yes 2	□No 3□Pro	obably 4 Minknown	
5 5	s beel	iete	Hyperlension	,				24a. W		24b. Were au	topsy findings available	
ב קר מי	certificate has rector, page 2	omp	1					aut pei 1 ☐ Yes	lopsy formed 2 No	death?	completion of cause of	
9	rtifica tor, p	3e C	25. Was case referred to medical				26. Place of D	eath (Check only				
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	i Direc	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify	•	City or 1	own, State	e)	iai riodio i vallibol,			
DIVISION OF VITAL DECOMES, F.C. DOA 00100,	within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai (		ician: To the best of my knowner: On the basis of examinat and manner stated.	on and/or in	vestigation, in my	opinion, death oc	curred at the tim	e. date an			
,	within To th	Me	29b. Signature and title of certifier			29c. Licer	ise number		29d. Da	ate signed (Monti	n, Day, Year)	
Í	,		> Stalings			29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) September 12, 2006 20e, Print) 29d. Date signed (Month, Day, Year) September 12, 2006 20e, Print) 20d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)						
	6		30. Name and address of person who con SUPN EET SALUDA	mpleted cause of death (Item	23a) (Type,	Print)	atol Mar	ndend				
	Sta	ate	31. Date filed (Month, Day, Year)	32/Registrar's Signay	ne V	TICK MUS	mu, a	7 (00 10)				
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Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28e-f ahow any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral	1 ☐ Never Marr 3 🛣 Widowed		Armed	Forces?		1					Rican, etc.)		Black, White	e, etc.	
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Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

Melvin Ellwood F		her 1- For State	State	of Maryla		rtment of	Health and	d Mental						
Divisio		Registrar  1. Decedent's Name	e (First Middle Las	t)	Cert	incate of	Death		2. Date of De	Reg No ath	20	0 5 ime 200 3 5		
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( ,		4a. Facility Name (i	f not institution, giv ce Street Apt 3		nber)		4b. City, Town, or Baltimore	Location of D	eath	4	c. County of $\tilde{\mathbb{N}}$			
Funeral		5. Social Security N			7 Age (In yrs la:	st birthday)	If Under 1 Year	If Under 2	4Hrs 8 Date of B	irth (MN	I/DD/YYYY) 9.	Birthplace (State or		
Director		217-02-10	5.7	M 2 F	38	Yrs	Months Days	Hours	Mar.	5, 1	1968 F	Country) MD		
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4arylar 28a-f s	ecto	10e. Street and Nu	mber		-		10f. Zip Code			10g Cr	tizen of What (	Country?		
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death with the Maryland or items 23a or 28a-f show must be notified at once.	Funeral Director	11. Marital Status  1 X Never Marri	ed 2 Married	Armed Fo	edent Ever in U.\$ rces? 2 X No	13. Wa	as Decedent of His es, specify Cuban	panic Origin? , Mexican, Pi	? ( Specify Yes or Nuerto Rican, etc.)	0-	14. Race - Al White, et	merican Indian, Black, c		
후 등 회		3 Widowed		1 Yes		1	Yes 2X No	specify			Specify.	White		
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5-0036 led within 7 Hygiene other than	Con	17. Father's Name	(First, Middle, Last	)		waz			Name (First, Middle	Maidei				
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MD 21 nd 2 should b lith and Mer m 27 is mar aumatic eve	To	19a Informant's Na	orris - S				,		ror Rural Route Ni 7d., Balt					
e, M I and 2 Health item 2		20a. Method of Dis	position				sition (Name of cer		Date			y or Town, State		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		1X Burial 2  A Donation 5	Other Specify			Cemeter	y		9-15-2006		Baltimo			
Salti ermit epartm nports njury e		21 Signature of Eu	ineral Service Lice		NO.				nbrose Fu					
Physician		23a. Part I. Enter the failure. List or	he disease or com	blications to at ca	aused the death.	Do not enter t	19 Hammo the mode of dying,	such as card	y Rd., L	anso	nock, or heart	Approximate Interval		
/Medical		failure. List or Immediate Cause		ach line. <b>Hypert</b> e	ensive Atl	heroscle	rotic card	iovascul	lar disease			Between Onset and Death		
₹xaminer		or condition results	ing in death)		consequence of				***					
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376C ficate g phys	J/Me	IF FEMALE 23b. Was decedent												
Box 6876 s death certificate the attending phy ed for use as the t	sician/M		to 12 months?  4 Pregnant at time of death 5 Other (Specify)											
	Phys	Part II. Other sign		3 Olikilo	-	esulting in the	underlying cause	given in Part	I 23e. Did	tobacc	o use contribut	e to the cause of death?		
P.O. es that the igned by	þ	-	tes Mellitu	_					_	es 2	No 3	Probably 4 Unknown		
Division of Vital Records, ral or Attending Physician: The law require is after death an Director: After this certificate has been sifted in by the funeral director, page 2 should b	Completed								24a Wa	s an		re autopsy findings available r to completion of cause of		
tal Reco	omp									formed [*]	? dea			
Vital Recc ysician: The lav his certificate ha director, page 2	Be C	25. Was case refe	rred to medical				26.Place		heck only one)					
Vita hysici this c	To B	examiner?	2 No		npatient 2	ER/Outpatier			Nursing Home 5	_	dence 6 🗸 (	Other: Scene		
Sion of Vital   Attending Physician: rdeath cetor: After this certif by the funeral director,		27. Manner of Dea	5 Pending	28a Date (Month	of Injury , Day,Year)	28b Time of		iry at Work? Yes 2 N		e now ir	njury occurred			
IVISIOR OF Attend after death Director:	icati	2 Accident 3 Suicide	Investiga 6 Could no	28e Plac	e of Injury - At ho	ome, farm, stre	eet, factory, office I	ouilding, etc			and Number of	r Rural Route Number, City		
Division  pital or Attent ours after death teral Director: filled in by the	Certification:	3 Suicide 4 Homicide	determin						or Town	State)				
Divisior To the Hospital or Attend within 24 hours after death To the Fineral Director: completely filled in by the		29a Certifier (Check only one)	Certifying Physi Medical Examin	cian. To the bes	of examination a	ge, death occu nd/or investiga	urred at the time, d	ate and place	e, and due to the ca irred at the time, da	use(s) a te and p	and manner as place, and due	started to the cause(s)		
Tour	Medical	29b Signat e n	-J	and manner s	tated		29c. Licens					(Month, Day. Year)		
		1 (4	1098	Al	10 as		O.C.	M.E.		Se	eptember 1	0, 2006		
		30. Name and add	dress of person who	completed cause			Street, Baltim	ore MD 2	21201					
S	tate	04.00 44.014.144			egistrar's Signatu		Zi GGC, Daitill							
Regis		0.000	1 5 2006	Men	w St.	front	<b>U</b>							
DHMH 17 Rev 1/2	2001					ÓRIGINA	AL							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day September 12, 2006 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b, City, Town, or Location of Death Hopkins HOSPHA timon3 Hours Min. 8. Date of Birth (Month, Day, Year)

Dec 25, 1954 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number Months Days 1[XM 2□ F Virginia 223-84-4653 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 1 ☐ Yes 2 No Dunda1k Md. Baltimore 10g. Citizen of What Country? 10f. Zio Code 10e. Street and Number 7413 Hill Court 21222 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian Black, White, etc. 1 ☐ Yes 2X☐ No If Yes, Give 1 Never Married 2 X Married 1 ☐ Yes X☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) William Walsh Const. 10th Construction 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) June Stryker Walter Funk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7413 Hill Court Baltimore, Maryland 21222 Mildred Funk (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition M☐Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 9-15-06 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facil & aczorowski Funeral Home, P.A. 21. Signature of Funeral Service Licenses Polis 1201 Dundalk Ave. Baltimore, Maryland21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Abotic VAINE REPLACEMENT 10 CARdiA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of deliver 23b. Was decedent pregnant 1 ☐ Live birth 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 2 No 1 Tyes 26. Place of Death (Check only one)

**Physician** /Medical **Examiner** 

The law requires that the death certificate be executed

Box 68760,

Division of Vital Records, P.O.

or Attending Physician:

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ir then "natural", or Iteme 23a or 28a-f ehow the Medical Exeminer must be notified at

nd 2 should be filed within 72 hours after death in the and Mental Hygiene.
27 is marked other then "natural", or freme 234 traumatic event, the Medical Examiner must

Pages 1 and 2 should nent of Health and Men

if item 27 is or other tre

Department of Important: If any injury or once.

Baltimore, Maryland 21215-0036

Completed by Funeral Director

Be

2

Examiner Physician/Medical þ Completed Be Certification: To

physician and s the burial-trans certificate has been si rector, page 2 should After this certification, s after dec. filled in by

25. Was case referred to medical

27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide

29a. Certifie (Check only one)

examiner?

5 Pending

1 Yes 2 No

investigation 6 Could not be determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

1 Hnpatient

28a. Date of Injury (Month, Day Year)

29c. License number

28c. Injury at Work?

1 Tes 2 No

29d. Date signed (Month, Dav. Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

RES-000

St Baltimore, Mary land

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

State Registrar

31. Date filed (Month, Day, Year) SEP 1 5 2006

FITTON

N. LUOIFE 400 32 Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA 28b. Time of Injury

within 24 hours a
To the Funeral I
completely filled

		For 1_ State	State of Ma	ryland / Dep	artment of h	lealth and	Mental Hyg	_						
Physic	cian	Registrer  1. Decedent's Name (First, Middle, L	ast)	CE	ertificate of	/ Dealin	2. Date of Death	n	(ear 9:55 AM					
/Med Exam	ical iner	4a. Facility Name (If not institution, g  Johns Howins Boy)  5. Social Security Number  6.	Sex P. Age	enter (In yrs. last birthday	4b. City, Town, of Baltino	If Under 24 H		4c. County of	Death  Birthplace (State or Foreign					
Funera Directo		212-01-3215 Usual Residence of Decedent	M 2□ F	90 Yrs.	Months Days	Hours Mi	s. Date of Birth (Month, Day, Sept 4)	^Y 1916	Indiana					
e Maryland ta-f show	Director	10a. State 10b. County  Maryland		10c. City, Town or I Baltimo					10d. Inside City Limits  TYYes 2 □ No					
3a or 28		308 South Oldham	Street		10f. Zip Code 21224		10	Og. Citizen of Wh	· ·					
and 21215-0036  be filed within 72 hours after death with the Maryland tall Hygiene.  and other then "natural", or Items 23a or 28a-f show event, the Mudical Examinar must be notified at	by Funerai	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Pres 2 N If Yes, Give Year or Dates:		. Was Decedent of H If Yes, specify Cub		(Specify Yes or No- erto Rican, etc.)	es or No- etc.)  14. Race - American India Black, White, etc.  Specify: Caucasi						
vithin 72 hou ene. then "nature the Mudical E	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12) 12th grade	Education rade completed)  College (1-4or 5-	<b>-</b> )	edent's Usual Occup e kind of work done DO NOT use retire		vorking	Steel C	6b. Kind of Business/Industry					
imore, Maryland 21215-0036 . Pages 1 and 2 should be filed within 72 hours alf irnent of Health and Mental Hygiene. tent: if item 27 is marked other then "natural", or jury or other traumatic event, the Mudical Exprangury or other traumatic event, the Mudical Exprangury or other traumatic.	a)	17. Father's Name (First, Middle, La Louis Fickus	st)	500	SET WOLKE		Name (First, Middle, M							
Mary nd 2 sho tith and A 27 is ma		19a. Informant's Name/Relationship Robert Fickus, se					Rural Route Number, eet, Balti							
imore, Marylar pentit. Pages 1 and 2 should be Dops fringen of Health and Menta Important: If Item 27 is marked any nijury or other traumatic en		20a. Method of Disposition  1 🕅 Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spec			position (Name of sematory or other plants Cemetery	_{ce)} Sept	Date 2		ity or Town, State					
Dept.rtn Imports any nju		21. Signature of Funeral Service Lice	ensee		22. Name and Addres	ess of Facility ill air Road	ler-Dippe , Baltimo	l Funera re, MD	11 Home, Inc. 21206					
Box 68760, eath certificate be executed attending physicien and for use as the burial-Iransit	cai Examiner	<u>a</u> d												
.O. Box 68 the death certifical y the attending phriched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	☐Ectopic pregnanc ☐ Other (specify) _	у		23d. Date Mont						
deta	à	Part II. Other significant conditions	contributing to death bu	it not resulting in the	underlying cause gr	ven in Part I.	23e. Did tob		oute to the cause of death?					
I Rec The law ate has b	Completed						24a. Was a autops perform 1 Yes 2	y pri ned? de	ere autopsy findings available for to completion of cause of ath? ☐ Yes 2™No					
Vision Attending or death. ector: Afte	Certification: To Be	25. Was case referred to medical examiner?  1  Yes	28a. Date of Injur (Month, Day	rv - At home, farm.	of 28c. Inju Wo M 1	ner: 4 Nursing	Death (Check only on g Home 5 Reside 28d. Describe ho 28f. Location (St City or Town	nce 6 Other						
Hospital or 24 hours afte Funeral Dir stely filled in		29a. Certifier 1 Certifying	Physician: To the best of aminer: On the basis of	of my knowledge, de	ath occurred at the ti	me, date and pla	ace, and due to the ca	iuse(s) and man	ner as stated.					
To the H within 24 To the F complete	Medical	one)  29b. Signature and title of certifier	and manner sta		29c. Licens				(Month, Day, Year)					
814		30 Name and address of person where Benjamin, 49	to completed cause of de	eath (Item 23a) (Type	Baltan	» Marcu	land 21	224	0,000					
S Regis	itate strar	31. Date filed (Month. Day, Year)	2006 32. egistra	r's Signature	forther a									

#### 06-06837 Louis Ray Gainer

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

ould ray Guine.		For State	Certif	icate of D	eath			1. No 2 [	106 2935				
Physician	ľ.	. Decedent's Name (First, Middle,Last)					Date of Death Month	Day Year	7. Time of Death 1229 hrs				
Medical Examine		Louis		Gain			September	10, 2006 4c. County of					
	4	a. Facility Name (if not institution, give stree	t and number)		City, Town, or Loc Clinton	ation of Death		Prince Ge					
		Southern Maryland Hospital	7 Age (In yrs last			If Under 24Hrs 8	Date of Birth	Date of Birth (MM/DD/YYYY) 9 Birthplace (State or					
Funeral Director	5	. Social Security Number 6. Sex 279-64-4415 1X M 2				Hours Min			Foreign Mewy York				
	_	Isual Residence of Decedent  0a State 10b, County	10c City To	wn or Location					10d Inside City Limits				
w any	1						1 X Yes 2 No						
Maryland 28a-f show d at once.	<u> </u>	Maryland Prince Geo Oe. Street and Number	rge's Fores	stville	Of. Zip Code		100	10g Citizen of What Country?					
the Maryland a or 28a-f sh iffied at once	3   1		"-0	Ι'									
ith the Maryland 23a or 28a-f shov		0004 Sherey Square L	ane #TZ  Was Decedent Ever in U.S.	13 Was F	20747 ecedent of Hispan	nic Origin? ( Speci		Yes or No- 14 Race - American Indian, Black,					
more, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland ten of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f shu other traumatic event, the Medical Examiner must be notified at once To Bo Completed by Eringral Director	֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	1 X Never Married 2 Married	Armed Forces?		specify Cuban, M			White,					
or in		3 Widowed 4 Divorced If Yes.	Yes 2 X No Give Year	1 Y	es 2 X No s	pecify:		Specify:	White				
urs aft	<u>-</u> ∫2	15. Decedent's Education (Specify only high	tes.	Sa Decedent's	Usual Occupation	(Give kind of work		16b. Kind of Bus					
5-0036 ed within 72 hour lygiene. other than "natu he Medical Exan	ط <u>ا</u> ا	Elementary/Secondary (0-12)	ollege (1-4 or 5+)	during most	of working life DC	NOT use retired	)						
215-0036 be filed within 7 ntal Hygiene. rked other that ent, the Medics			2	Home	naker			Own Ho	me				
5-00 ed wi tygies other		7. Father's Name (First, Middle, Last)		-	181	Mother's Name (F	irst, Middle, M	aiden Surname)					
21: De fill ring I in red		'Unknown''				Charlie 1							
MD 21215-005 and 2 should be filed within that and 27 is marked other th aumatic event, the Med To Bo Comm	2 1	9a. Informant's Name/Relationship (Type, F	1.9		ddress (Street ar				1				
MC slid 2 slitth ar m 27 auma	-		•		Morelane n (Name of cemet		everane		City or Town, State				
ore, Mes I and 2 of Health If item 2		20a. Method of Disposition  1 X Burial 2 Cremation 3 Re		matory or other									
Page nent cant cor oth		4 Docation 5 Other Specify:	Oakw	Oakwood Cemetery 9/15/06 Niagara Falls, NY									
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural" injury or other traumatic event, the Medical Examine To Bo Compulated by		21. Surfature   f Funeral Service Licensee	-	Wil	ne and Address of <b>liamson</b>	Funeral	Home						
	1	23a Part I. Enter the disease, or complication	Niaga	ra, NY	14301 st shock or hear	t Approximate Interval							
Physician /Medical	ľ	failure. List only one cause on each lin	e.						Between Onset and Death				
Examiner		Illinodiate order (t iii = = = = = = = = = = = = = = = = =	thadone intoxica (or as a consequence of):	atton con	рисасива	abdollmar .	щитеs						
K.,		Sequentially list conditions, b	(0. 40 4 00,000 4 00,000 0,000										
	<u> </u>	if any, leading to immediate  Cause. Enter Underlying Cause	o (or as a consequence of):										
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687 certific		3b Was decedent pregnant in the past 12 months?	Live birth Pregnant at time of deat	2 Feta		Ectopic pregnanc	У	Month	Day Year				
Box 687 he death certific	Sic	1 Yes 2 No 9 Unknown 9	Unknown	5 Othe	r (Specify)			1					
that the dated by the detached	Physician	Part II. Other significant conditions cont		ulting in the un-	derlying cause give	en in Part I.	23e. Did to	bacco use contrib	oute to the cause of death?				
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ords, w require us been si should t	e e						24a Was a		Vere autopsy findings available				
Cords, faw requir has been e	Completed	<u> </u>					autops perfor	med? de	eath?				
tal Reco		25. Was case referred to medical			26 Place of	Death (Check on		2 No 1	Yes 2 No				
Vital Fysician:	ă۱	examiner? Hospit	al: 1 Inpatient 2 🗸 E	R/Outpatient	Ot	her ₄ Nursing I		Residence 6	Other				
of Vilding Physic After this funeral direction		1 Yes 2 No 27 Manner of Death	28a. Date of Injury 2	28b. Time of Inj		at Work? 25	8d Describe h	now injury occurre	ed .				
nding nding nh.	틸	1 Natural 5 Pending	(Month, Day, Year) Fnd 9/10/2006	Fnd 11:3	Oam 1 ☐ Yes	s 2 X No	unknown						
IVISIOI I or Attendather death Directors	lica	2 Accident Investigation 3 Suicide 6 X Could not be	28e. Place of Injury - At hon	8f. Location (S	Street and Numbe	er or Rural Route Number, City							
Divisior pital or Attencours after death	Certification	Suicide 6 X Could not be determined	(Specify) Found in	residenc	F	orestvi1	le. MD	Surrey Square Lane					
		29a Certifier 1 Certifying Physician:	Γο the best of my knowledge	e, death occurre	d at the time, date	and place, and do	ue to the caus	e(s) and manner	as started				
To the Ho within 24 To the Fu completely	Medical	and	the basis of examination and manner stated	d/or investigation			he time, date						
F > F 0	ž	29b. Signature and title of certifier	10		29c License				ed (Month, Day, Year)				
		Janalla C	1		O.C.M.	.C.		September	11, 2000				
	İ	30. Name and address of person who comp			Street, Baltim	nore MD 2126							
			t Medical Examiner  32 Registrar's Signature	a 2		IOIG, IVID Z 1Z(							
Sta Registi		31 Date filed (Month, Day, Year) SFP 1 5 2006	32 Registral's Signatur	Spea									
	_			- 6									

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registre Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 9:12 a M Sept. 14, 2006 FREDERICK ROSS GRAY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Pasadena Anne Arundel Locust Lodge Assisted Living If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 25, 1918 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex. **Funeral** Canada 87 Yrs Director 133-24-9273 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location Show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Anne Arundel Pasadena items 23a or 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 150 Park Road 21122 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: if item 27 is marked other than "natural; or iter 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White Completed by 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Sales Manager traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Fulford Murei1 В. Ross Gray Thompson ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 150 Park Road, Pasadena, Maryland 21122 Dan S. Gray (Son) other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Department of Important: if any injury or once. injury or Bayview Crematory 09-15-06 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility
McCully—Polyniak Funeral Home P.A. 21. Signature of Funeral Service Licenses 3204 Mountain Road, Pasadena, Maryland 21122 23a. Port1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest prock, or heart failure. List only one-cause on each line. Approximate Interval Between Onset and Death mediate Cause (Finat STA6E Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part.U. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 HOther (Specify) Assisted 1 ☐ Yes 2 → No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ Living 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 28b. Time of Certification: 1 WNatural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 🕳 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 30. Name and address of gerson who completed cause of death (Item 23a) (Type, Print) Kolling Crossroads 31. Date filed (Month; Day, Year) 32. Apgistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2005

29360

		7 - State Registra	r					Cei	rtific	ate of	Death	7		Reg. N	اه. کے ک	00	23300
1. Decedent's Name (First, Middle, Last) Physician													2. Date of D		ay	Year	3. Time of Death
	sician edical				Thoma	s Wa	ayne G	Graft	on,	Sr.			Septe	mbei	r 6,	2006	10:15 AM
	miner	4a. Facility Na	ime (If not institutio	n, give s	treet and nu	m <i>ber)</i>			4b. C	City, Town,	or Location	of Death		4	c. Count	y of Death	
		Gilc	hrist Cen	ter					Ва	altimo	ore			1	Balti	imore	
Fune	ral	5. Social Secu	urity Number	6. Sex		7. Age	(In yrs. las	t birthday)		nder 1 Year		r 24 Hrs.	8. Date of B	irth	rel .	9. Birthp	lace (State or Foreign
Direct		218-	68-0550	1 🕸	M 2□F	4	9	Yrs.	Mon	ths Days	Hours	Min.	Oct 1	2, 1	956	Mary	land
D		Usuel Reside	nce of Decedent														
ylan		10a. State	10b. County	/			10c. City, 1	Town or Lo	ocation							1	Od. Inside City Limits
Ma	ģ	MD	Howar	d			E1kr	ridge									1 ☐ Yes 2 🛣 No
r 282	Director	10e. Street ar	nd Number						10f	. Zip Code				10g. 0	Citizen of	What Coun	itry?
3a o		8003	Keeton R	bso!						21075				U	S.A.		
5-UU36 72 hours after death with the Maryland natural, or Iteme 23a or 28a-1 ehow	Funeral	11. Marital St			2. Was Dec	edent E	ver in U.S.	13.			Hispanic O	rigin? (Spe	cify Yes or N Rican, etc.)	lo-	14. Race - American Indian,		an Indian,
fter (	교	1 Never	Married 2 X Mar	ried	Armed F 1 ☐ Yes		0	1					Rican, etc.)		Bla	Black, White, etc.	
Se all'io	2	3 ☐ Wido	wed 4 □ Divorced		If Yes, G Year or I	ive			1 🗌 Ye	s 2X No	Specify	<b>/</b> :			Specify: White		te
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with the same	Completed	1.0	/Secondary (0-12)		College	1-40r 5-	+)	Carp	ent	er				Construction			on
THY BE	Ö	17. Father's N	lame (First, Middle,	Last)						·	18. Moth	ner's Name	(First, Middl	e, Maide	den Sumame)		
Baltimore, Maryland 21215-0036  semit. Pages 1 and 2 should be filed within 72 hours alt  Department of Health and Mental Hygiene.  Importants: If lear arked other then 'natural', or  my fullyry or other traumatic event, the Medical Exami	B	Poho	rt Grafto	'n							Bar	bara	Jean F	err	V		
A Merit	ပို		nt's Name/Relations		ne Print)			19h Mailir	ng Add	race /Stran	!		/ Route Num			State Zin	Codel
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Iteme 23e or 28e-1 ehow any injury or other traumatic event, the Madical Examiner made notified as			n L. Graf			150			-				idge,				,
the Tan		20a. Method			/ spot	156	20h Plac	e of Dispo			Roau,		ate		4	· City or To	
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IIII men tent:		4 □Donation 5 □Other (Specify) Dulaney Valley Mem Gdn Sep 9, 06 Timonium,													um, Ma	aryland	
Samit Sparrit Sporrit Sporrit Sy In	SUC.	21. Signature	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389														
<b>Ⅲ</b> %∆5 %	a		M007/3 313 Talbott Ave. Laurel, Maryland 20707-43  23a. Partl. Enter the mode of dying, such as cardiac or respiratory arrest.  Approxima														707-4389
		23a. Part1. E	nter le list se, o	r complic	cations that	caused	the death.	Do not ent	er the	mode of dy	ng, such a	s cardiac o	respiratory	arrest,			Approximate Interval Between
Physicia		Immediate C	Immediate Cause (Final disease or condition														Onset and Death
/Medic		resulting in death)  a. UpwhomA  Due to (or as a consequence of):												umins			
Examin	er																
	9	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  Due to (or as a consequence of):															
P B E	를	cause. Enter Underlying Cause (Disease or injury															
and and	Examiner	that initiated or resulting in de	events eath) Last	С	. Due to	(or as a	a consequer	nce of):			-	-					
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ox 68760, C certificate be executed ding physicien and ise as the burial-transit	/Medicat	IF FEMALE:		01	20 16		-4										
	an	23b. Was ded	cedent pregnant ast 12 months?	2.		birth :	2 ∏Fetal de	eath 3		ic pregnanc	у					ate of delive onth	ry Day Year
	Physicial	1 🗆 Yes	2 🗆 No		4∐Preg 9☐Unkr		time of deat	th 5[	Othe	r (specity) _						0.711	Day
hat the do do by the detached	, Å	9 🗆 Unk															
S, I ssth gned seded	à	Part II. Other	significant conditi	ions con	tnbuting to	death bu	it not resulti	ng in the u	nderlyii	ng cause gi	ven in Part	1.	23e. Did	tobacco	o use con	tribute to th	e cause of death?
equire en si	P												1/2	Yes	2 □ No	3 🗌 Prob	ably 4 □Unknown
W we show show	Completed												24a. Wa		24b.	Were auto	psy findings available
HeC he lav e hes													per	opsy formed?	' ]	death?	npletion of cause of
Ficate T	ပိ	OF Manager	referred to medica										1 Yes		No	1 🗆 Yes	2 L No
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DIVISION OF VITAL RECORDS, I or Attending Physician: The law requires I after death.  Director: After this certificate hes been signs in by the funeral director, page 2 should be.	<u>0</u>	1 Natur	al 5 🗌 Pendi		(Moi	nth, Day	Year)	Injury		28c. Inju Wo			od. Describe	now in	jury occui	пеа	
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or At or At or At or At or Direct in by	Certification:	4 Hom	dotom				iry - At homi :. (Specify)	e, farm, str	reet, fac	ctory, office		2	Bt. Location City or To			ber or Ruma	l Route Number,
DIVISION Of VITAI HE To the Hospital or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	ပီ																
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To t	Σ	29b. Signatur	eand time of certific	or n						29c. Licen	se number			29d. E	ate signe	ed (Month, i	Day, Year)
			Marca							1) 5	830	5		de	pter	ber	1 200%
10		30. Name and	d address of person	who co	mpleted cau	se of de	eath (Item 2	3a) (Type,	Print)						- 3	300	Day, Year) 7 Jeogs
19		AN	( 0		in	6	601	N. (	in	was	St 1	SACR	no	W.	) 4	204	
	State	31. Date filed	(Month, Day, Year		32.	Régistra	ır's Signatur	9	100	de l'							
	istrar		SEP 1	D 41	100	W. Alex	your of	1									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** September 11, 2006 6:40 AM Gray, Sr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 38 Colony Hill, Apt. 2A Halethorpe Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth Apr. 20, 1927 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Yrs. Director 214**-**22**-**3530 79 death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "neturel", or Items 23s or 28s-f show event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Baltimore Halethorpe Direct 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 38 Colony Hill, Apt 2A United States

14. Race - American Indian,
Black, White, etc. 21227 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 end 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "neturel; or Iten any injury or other treumatic event, the Medical Examina 1 2 Yes 2 No 1945 -1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No þ Specify. 3 ₩ Widowed 4 Divorced White Year or Dates Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Corrections Officer State of Maryland 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry B. Gray ٩ <u> Gladys L. Pilkerton</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gilbert F. Gray, Jr. - Son 1404 Orr Court, Pasadena, MD 21122 90b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Cedar Hill □ Burial 2 □ Cremation 3 □ Removal from State
□ Donation 5 □ Other (Specify) 9-14, 2006 Brooklyn, MD Cemeter Andress of Facility Ambrose Funeral Home, Inc. 21. Signature of Juneral Service Lic 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Hypotension ew doies disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner bleeding Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as the attending physician and Kined for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed δ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No 1 Inpatient 2 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Déscribe how injury occurred After 1 Certification: 5 Pending investigation 1 Natural
2 Accident 1 ☐ Yes 2 ☐ No Director 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai (Check only one) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 127541 September 11,2006 Cicema Laya MI 30. Name and address of person who completed cause of death (Item, 23a) {Type, Print), Fory Rd, Baltmon 4367 Holline RAJA MD GEETHA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 5 2006 Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of N	laryland /		tment of				giene Reg. No. 2	006	29362
	Physici	an	1. Decedent's Name (First, Middle, La	,	0:11:	1				2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Medic		Henry  4a. Facility Name (If not institution, gir	W .	Gillia		lb. City, Towr	or Locatio	on of Dooth	Septemb		2006 nty of Death	10:05 P M
	Examin	er	4708 Coachway Dr		'/	'	-	ockvi			4c. Cou		gomery
	Funeral		Social Security Number 6.	Sex 7. /	ige (In yrs. last b		If Under 1 Ye	ar If Und	ler 24 Hrs.	8. Date of Birt (Month, Da	h Vear		oplace (State or Foreign
	Director		410-01-0200	1⊠M 2□F	86	Yrs.	Months Day	ys Houi	5 PATEL	February	25, 192	0 A1	abama
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tox	wn or Locat	tion						10d. Inside City Limits
	Mary -f sho	tor	Maryland Montg	omerv		Ŕ	lockvi]	116					1 ☐ Yes 2X No
	or 28a	Director	10e. Street and Number	oe 2 )			10f. Zip Cod				10g. Citizen o	of What Cor	untry?
	23a c	al D	4708 Coachway Dr	ive				20852			Unite	ed Sta	ates
	er dez	nue	11. Marital Status	12. Was Deceder Armed Forces	3?	13. Wa	s Decedent of es, specify C	of Hispanic uban, Mexic	Origin? (Sp can, Puerto	ecify Yes or No- Rican, etc.)	14. R	lace - Amer	ican Indian, , etc.
36	rs aft	by Funeral	1 Never Married 2 Married 3 ⊠Widowed 4 Divorced	1 Types 2 [ If Yes, Give Year or Dates	] No : WWT T	1 🗆	Yes 2⊠1	No Speci	ity:		Spec	cify: Wh	ite
Š	within 72 hours after death with the Maryland ene. then "natural", or items 23a or 28a-f show the Medical Ezam at must be notified at		15. Decedent's E	ducation		a. Deceden	nt's Usual Occ	cupation			16b. Kind of		
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ano	ntal Hed of	Be	17. Father's Name (First, Middle, Last Columbus J. Gi					18. Mo		e (First, Middle, Le. P. C.)			
Maryland 21215-0036	Should Me Me mark	10	19a. Informant's Name/Relationship		19	b. Mailing A	Address (Stre	et and Nun	<del></del>	al Route Numbe			in Code)
Ž	s 1 and 2 should be filed within 72 hours after death with the Marylan of Heelth and Mental Hygiene. Item 27 Is marked other then "natural", or Items 23a or 28a-f show other traumatic avant, I'm Medical Exam at must be notified at		Thomas P. Gillian	d/Son						rsburg, N			
ore	of He of He f fterr r oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Domoual from Stat	20b. Place	of Disposition	on (Name of ory or other p	-	ľ	Date	20c. Location		
Ĕ	Pag ment tant: I		4 Donation 5 Other (Speci			mery C	remator	ium	Sept 15,	ember 2006	Bethes	da, M	aryland
Baltimore,	permit. Pages. Department of It Important: If ite eny Injury or ot once.		21. Signature of Funeral Service Lice		M01473	Robe 300	ert A. I W. Mont	dress of Fac Pumphre Egomery	y Fune Avenu	ral Home, e, Rockv	Rockvi ille, Ma	lle, I ryl <i>a</i> nd	nc. 20850
	Physician /Medical	8 4	23a. Part1. Enter the disease, of conshock, or heart failure. Lift only immediate Cause (Final disease or condition resulting in death)	_a_Metast	atic Ad	enoca			as cardiac d	or respiratory an	rest,		Approximate Interval Between Onset and Death
8760,	ate be executed by sicion and purial-transit and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a	s a consequence	e of):							
P.O. Box 6	ettending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e of pregnancy 2 Tetal death at time of death		topic pregnal ther (specify)				1	Date of deliver	very Day Year
rds, P	w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions of Coronary Artery		but not resulting	in the unde	rlying cause	given in Pai	rt I.		••		the cause of death? bably 4 Unknown
Division of Vital Records,	ysician: The law ra his certificate hes be director, page 2 sh	Completed								24a. Was a autopoperfor	sy	Were autoprior to condeath?	opsy findings available ompletion of cause of
VIII VIII	certifi	Be	25. Was case referred to medical examiner?	Hospital:			10			Check only or			
ion of	ding Pl h. After th funeral	atlon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident Investigatio	28a. Date of In (Month, D	ury 28b.	Time of Injury	28c. In	ijury at vork?		me 5 to Resid			fy)
Divis	Hospitel or Attandi 24 hours after death Funerel Director: A stely filled in by the f	Certification:	3 Suicide 6 Could not be determined	286. Place of I	njury - At home, f etc. (Specify)	arm, street,	, factory, offic	ee ·		28f. Location (S City or Tow	treet and Nun n, State)	nber or Rur	al Route Number,
	To the Hospitel or Al within 24 hours after of To the Funerel Direct completely filled in by	edical	one) 2 Medical Exer	nysician: To the bes niner: On the basis and manner s	of examination a	e, death oc nd/or invest	tigation, in m	y opinion, d	eath occurr	and due to the c ad at the time, d	ause(s) and r late and place	manner as s	stated. o the cause(s)
١	To Tro I	Σ	29b. Signature and title of certifier	0		1	29c. Lice D20	nse numbe	r		9d. Date sign		Day, Year) 2, 2006
•	nul	-	rel (o	cup.	Mi	<i>U</i> .					ось есиг	CT 17	., 2000
	1771		Joel Kalman, M.D.		death (Item 23a) .ccard Di			ille.	Marv	Land 20	0850		
1	Sta	te	31. Date filed (Month, Day, Year)	32 F	trar's Signature			,	y -				
1	Registra	ar	SEP 152	2006	un K	500	We see						

			1 - Stata Registrar	State of M	aryland / De	partmen <i>ertificate</i>			d Mental Hy		200	6	29363
9	Physici	an	1. Decedent's Name (First, Middle, Last,		· · · · · ·			-	2. Date of De Month	eath Dav	Ye	ar	3. Time of Death
	/Medic	al	Daisy Green  4a. Facility Name (If not institution, give:	treat and number		4h Cihi	Tours or I	Location of D	Septen		12 20 County of E		10:10 AM
1	Examin	ęr	Wicomico Nursing				Salis		eatti	40.	WICO		<b>3</b>
	Funeral		5. Social Security Number 6. Sec	7. Ag	e (In yrs. last birthd			If Under 24 I	Hrs. 8. Date of Bi	rth	9.	Birthpla Counti	ace (State or Foreign
L	Director		224-03-7282	M 2⊠F	90 Yrs	·	Days	riours	July 15	, 19	16	VA	
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	Location		<del></del>				10	d. Inside City Limits
	a-f sh	ctor	MD Wicomico	1	Salisbu	сy							1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number		·	10f. Zip	Code			10g. Citi:	zen of Wha	Count	ry?
	s 23a	eral	900 Booth Street	10. Was Danadast	Francis II S		802		3 /0	USA			
10	fter de	Funeral	11. Marital Status unk	12. Was Decedent Armed Forces? 1    Yes 2   X		If Yes, spec	ent of His offy Cuban	, Mexican, Pi	? (Specify Yes or No uerto Rican, etc.)		14. Race - A Black, V		
8	rel', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes	2⊠ No	Specify:			Specify: 1	olac	:k
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "neturel", or items 23a or 28a-f show event, I'm Medical Evarilier must be notified at	Completed	15. Decedent's Edu (Specify only highest grad		(G	cedent's Usua ive kind of wor	rk done du	iring most of	working	16b. Kir	nd of Busine	ess/Indi	ıstry
12	withir iene. than	duc	Elementary/Secondary (0-12)	College (1-4or none	5+)	э. <i>DO NOT</i> us emb1y I				Car	mpbel	1 S/	nun
קס	il Hygi other	Be Co	17. Father's Name (First, Middle, Last)	none	1133	cmbry i		18. Mother's	Name (First, Middle			I DC	, up
ylar	Menta Menta arked	To E	James Green				A	nnie H	loward				
Mar	12 sho h and 7 is m reum		19a. Informant's Name/Relationship (Ty						r Rural Route Numb			e, Zip (	Code)
ē,	1 and Health tem 2		Wanda Thompson/fri 20a. Method of Disposition	ena	20b. Place of Di	sposition (Nan	ne of		Mardel,		1837 cation - City	or Tov	vn, State
OE I	Pages ent of nt: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ F  1 ☐ Surial 2 ☐ Cremation 3 ☐ F	emoval from State	cemetery,	rematory or o	ther place				,		
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel; or Items 23a or 28a-f show eny injury or other treumatic event, the Medical Engineer must be notified at once.		21. Sign stare of Fineral Service Licens, Ronald S.	Wade fir	ector	22. Name an State Baltim	d Address Anato	of Facility	ard 655 W 201	. Bal	timor	e S	treet
			23a. Parl1. Enter the disease or complishook, or heart failure. List only or	cations that cause	the death. Do not	enter the mod	e of dying	such as care	diac or respiratory a	rrest,			Approximate Interval Between
E	Pnysician		Immediate Cause (Final disease or condition			ESPIL							Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):		, ,					T	
	- %	e	Sequentially list conditions,	CHF	a consequence of):								
	uted d ansit	Examiner	all any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ASCVI									
Ő,	e exec ian an urial-tr	Exa	resulting in death) Last	Due to (or as	a consequence of):								
8760,	icate be executed physician and s the burial-transit	dical		J								i	
Box 6	eath certific attending p	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome						2	3d. Date of	deliver	v
Ď.	ne death the atte hed for	sicia	in the past 12 months?	1∐Live birth 4∐Pregnant a 9∐Unknown		3 □Ectopic pr 5 □ Other (sp					Month		Day Year
P.O.	that the de ed by the a detached f	Phys	9 Unknown		unt mat annulting in th			in Death	O2a Did	laha saa		- to the	serves of death?
Vital Records,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ted by		LITUS	out not resulting in th	underlying ca	ause giver	1 in Part I.		Yes 2		robai	cause of death?
ecc	law ra nas be s 2 sh	Completed	HYPERTENSION						24a. Was	psy	24b. Were prior	autop:	sy findings available pletion of cause of
a H	sicien: The law certificate has b irector, page 2 s		OBESITY.						1 ☐ Yes	2 No	death 1 🗆	n? Yes 2	!□ No
	sicier s certif irecto	o Be	25. Was case referred to medical examiner?	lospital:	ent 2 ☐ ER/Outpa	tiont 3000			Death (Check only only only only only only only only		Other /	Canaif d	
Of	g Phys ter this neral di	$\vdash$	27. Manner of Death	28a. Date of Inju (Month, Da	irv 28b. Tim		8c. Injury	at	28d. Describe			респу	
sior	endin eath. or: Afi	catio	Natural 5 Pending investigation	(11.511.1)	, , , , , , , , , , , , , , , , , , , ,	M		es 2 🗆 No					
Division of	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	ertification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of In building, e	ury - At home, farm, c. (Specify)	street, factory	, office		28f. Location ( City or To	Street and wn, State)	f Number of	· Rural i	Route Number,
	To the Hospitel within 24 hours a To the Funeral I completely filled	O	29a. Certifier Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical	sician: To the best	of my knowledge, d	eath occurred	at the time	a, date and pl	ace, and due to the	cause(s)	and manne	r as sta	ted.
	he Ho n 24 h he Fu	Medical	(Check only 2 Medical Exami	ner: On the basis of and manner st	f examination and/o	investigation,	in my opi	nion, death o	occurred at the time,	date and	place, and	due to t	he cause(s)
	To t To t	Σ	29b. Signature and title of certifier	0-			License	number 6319	9	29d. Date	signed (M		
			1 perli				ν υ C	6319	7.	09	114	200	6
			30. Name and ddress of person who co Yogesh Vohra M.D.		ternshore		alish	ourv M	21804				
98	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	Also I		,					
	Registr	ar	SEP 1 5 2006	for the short	The second								

			1- State of Maryland / Dep Registrar Ce	artment of Health and Me	ental Hygien Reg. N	2006 29364
	Physici		1. Decedent's Name (First, Middle, Last) Thomas F. Harrison		2. Date of Death	3. Time of Death 10:17 a M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Gilchrist Center	4b. City, Town, or Location of Death		4c. County of Death
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Towson  If Under 1 Year   If Under 24 Hrs.   Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	Baltimore  9. Birthplace (State or Foreign Country)
	Director		216-30-6385 To A Constitution of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series	Months Days Hours Min.	une 11, 1	1934 Maryland
	yland sow		10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	Ba-fet	ctor	Md. Harford B	el Air		1 ☐ Yes 2 ☐ No
	with th	Funeral Director	10e. Street and Number	10f. Zip Code		Citizen of What Country?
	ns 23	erai	205K Burkwood Court           11. Marital Status         12. Was Decedent Ever in U.S.         13.	21015 Was Decedent of Hispanic Origin? (Spec		J. S. A.  14. Race - American Indian,
920	urs after o	þ	Armed Forces?  1 ☐ Never Married 2 ☑ Married  1 ☐ Never Married 2 ☑ Married  1 ☐ Yes 2 ☐ No  If Yes, Give  Year or Dates:	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R 1 ☐ Yes 2 ☑ No Specify:	ican, etc.)	Black, White, etc.  Specify: white
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Items 23e or 28e-f ehow any injury or other traumatic event, Ite Madical Explicat most be notified at once.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	g 16b.	Kind of Business/Industry
22	iled w Hygier ther th	Co	12 years c	rane operator		construction
au	id be i ental i ked o	To Be	William F. Harrison	Bertha S		on Sumane,
ary	should Mand Mand	H		ing Address (Street and Number or Rural	Route Number, City	·
<b>∑</b>	and 2 lealth m 27 i		Jane F. Harrison/wife 205			
Baltimore,	Pages 1 nent of H nt: If its iry or ot		I C Duliai 2 Commation 3 Chemoval Ilom State 1	osition (Name of Imatory or other place)  Cemetery 9/18/	200.	Location - City or Town, State
Balti	permit. Departn Importe any inju		21. Signature of Funeral Service Licensee	2. Name and Address of Facility Schimunek Funeral H	ome of Be	l Air, Inc.
			23a. Part1. Enter the disease, or complications that caused the death. Do not en		respiratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a.     Schmic   Course (Final disease or condition resulting in death)	ardiongopathy		years
	Examiner		Sequentially list conditions, b			
T	ted nsit	Examiner	ir any, leading to immediate cause. Enter Underlying cause. Enter Underlying Cause (Disease or injury			
v O	execu an and rial-tra	Exar	that initiated events resulting in death) Last c.  Due to (or as a consequence of):			
8760,	ate be executed the burial-transit	icai	d			
	ding pl	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy			m1 D
P.O. Box	es thet the death certific igned by the attending p be detached for use as	Physician/Med	in the past 12 months?	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
rds, P	Attending Physicien: The law requires that the death certificate be executed robath. robath. ector: Alth. ectoring physicien and by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit	ρ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Munknown
Division of Vital Records,	The law re te has bee age 2 sho	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
<u>t</u> a	ysicien: The is certificete hadirector, page	BeC	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)	
of O	Physic this or al dire	ပ္	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	nt 3 DOA Other: 4 Nursing Home		6 ther (Specifyhospice
sion	r Attending Phy er death. irector: After this by the funeral c	ertification:	1 Matural 5 Pending (Month, Day Year) Injury 2 Accident investigation	of 28c. Injury at Work?  M 1   Yes 2   No	3d. Describe how in	ury occurred
Ö		O	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	treet, factory, office 28	3f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	To the Hospital or within 24 hours afte To the Funeret Dir. completely filled in	edical	29a. Certifier Check only (2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, an ovestigation, in my opinion, death occurred	nd due to the cause d at the time, date a	(s) and manner as stated nd place, and due to the cause(s)
	To tl withii To tl comp	W	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year) Otember 13 2006
•	0	24	· March	0 58303		17 000
	U		30. Name and address of person who completed cause of death (Item 23a) (Type AANON Charles, my LGO; N. Charles	des st spanne u	o sisay	
	Sta Registr	_	30. Name and address of person who completed cause of death (Item 23a) (Type AANN Charles, my LCO; Nr Charles)  31. Date filed (Month, Day, Year)  32. Registrar's Signature  SFP 1 5 2006	and a		

			For Stata Registrar		epartment of Hea Certificate of De	eath	Reg. No. 20	
	Physici /Medio Examir	al	Decedent's Name (First, Middle, Last)     Evelyn Foster Hil     4a. Facility Name (If not institution, give	1 street and number)	4b. City, Town, or Loc	Sept	of Death h Day cember 13,	f Death
	Funeral Director		Brighton Nursing  5. Social Security Number  105-18-4790  Usual Residence of Decedent	7. Age (In yrs. last birth	nday) If Under 1 Year If	Under 24 Hrs. 8. Date (Mont) Oct.	of Birth th, Day, Year) 10, 1910	N/A  9. Birthpface (State or Foreign Country)  Massachusetts
	ith the Maryland or 28a-f show	Director	10a. State 10b. County MD N/A 10e. Street and Number	10c. City, Town	Baltimore		10g. Citizen of W	,
720	within 72 hours after death with the Maryland ene. Then "natural", or items 23e or 28e-f show na Maulcal Exeminer must be mullised at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No It Yes, Give Year or Dates:	212:  13. Was Decedent of Hispa If Yes, specify Cuban, N  1  Yes 2 No S			States - American Indian, t, White, etc. White
Maryland Z1Z15-0030	be filed within 72 hours after death with the Marylan Hygione.  I Hygione.  I other than "natural", or liems 23a or 28a-f show to other than "natural", or liems 23a or 28a-f show are not the Madical Examinar must be notified at	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12	e completed)	Decedent's Usual Occupation (Give kind of work done durin life, DO NOT use retired)  Psychologis	ng most of working		thcare
lyianu	hould be fil d Mental H marked otl matic even	To Be	Jacob Foster  19a. Informant's Name/Relationship (Ty	roe Print) 19h	Mailing Address (Street and	Fanny Davi	LS	
Dalillore, Ma	permit. Pages 1 and 2 should be Department of Health and Menta important: if Item 27 is marked any injury or other traumatic evonce.		Jane Stokes - daug  20a. Method of Disposition  1 Surial 2X Cremation 3 F  4 Donation 5 Other (Specify)  21. Signature Company	hter 119 20b. Place of Western Crema	Disposition (Name of Company of Other place)	, Towson, MI Date 9-15-2006	21204 20c. Location - 0 Odenton	City or Town, State
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or compl shock, or heart faifure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of	of parkman	uch as cardiac or respira	•	Approximate Interval Between Onset and Death
T.O. DOA 001	es that the death certificate igned by the attending phy: be detached for use as the	by Physician/Medical	was decedent pregnant in the past 12 months?  1 □ Yes 2 No 9 □ Unknown  Part II. Other significant conditions con		3 ☐ Ectopic pregnancy 5 ☐ Other (specify) the underlying cause given in	n Part I. 23e.	. Did tobacco use contri	of delivery th Day Year bute to the cause of death?  3 □ Probably 4 □Unknown
vital necolus,		Completed	Cerebronsular d	verse		24a.	. Was an autopsy performed?	/ere autopsy findings available rior to completion of cause of eath?
5	tending Physic leath. tor: After this ce the funeral direc	Certification; To Be	25. Was case referred to medical examiner?  1	4 Nursing Home 5 28d. Des 2 No 28f. Loca	eath (Check only one)  Home 5 Residence 6 Nother (Specify) Assisted 4  28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route Number,			
Ē	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical Certi	29a Certifier 1 Certifying Phy	28e. Place of Injury - At home, far building, etc. (Specify) sician: To the best of my knowledge, ner: On the basis of examination and and manner stated.	death occurred at the time.	date and place, and due	or Town, State) to the cause(s) and mar time, date and place, a	nner as stated. nd due to the cause(s)
	rough vithi	W	29b. Signature and title of certifier  30. Name and address of person who co	omer: On the basis of examination and and manner stated.  completed cause of death (Item 23a) (  completed cause of death (Item 23a) (  completed cause of death (Item 23a) (  completed cause of death (Item 23a) (  completed cause of death (Item 23a) (  completed cause of death (Item 23a) (  completed cause of death (Item 23a) (  completed cause of death (Item 23a) (  completed cause of death (Item 23a) (  completed cause of death (Item 23a) (  completed cause of death (Item 23a) (  completed cause of death (Item 23a) (  completed cause of death (Item 23a) (  completed cause of death (Item 23a) (  completed cause of death (Item 23a) (  completed cause of death (Item 23a) (  completed cause of death (Item 23a) (  completed cause of death (Item 23a) (  completed cause of death (Item 23a) (  completed cause of death (Item 23a) (  completed cause of death (Item 23a) (  completed cause of death (Item 23a) (  completed cause of death (Item 23a) (  completed cause of death (Item 23a) (  completed cause of death (Item 23a) (  completed cause of death (Item 23a) (  completed cause of death (Item 23a) (  completed cause of death (Item 23a) (  completed cause of death (Item 23a) (  completed cause of death (Item 23a) (  completed cause of death (Item 23a) (  completed cause of death (Item 23a) (  completed cause of death (Item 2a) (  completed cause of death (Item 2a) (  completed cause of death (Item 2a) (  completed cause of death (Item 2a) (  completed cause of death (Item 2a) (  completed cause of death (Item 2a) (  completed cause of death (Item 2a) (  completed cause of death (Item 2a) (  completed cause of death (Item 2a) (  completed cause of death (Item 2a) (  completed cause of death (Item 2a) (  completed cause of death (Item 2a) (  completed cause of death (Item 2a) (  completed cause of death (Item 2a) (  completed cause of death (Item 2a) (  completed cause of death (Item 2a) (  completed cause of death (Item 2a) (  completed cause of death (Item 2a) (  completed cause of death (Item 2a) (  completed cause of	Type, Print)  Larles J + B	amber 303 Satimere e	Scytem 21204	(Month, Day, Year)
	St Regist	ate rar	31. Date filed (Month, Day, Year) SFP 1 5 2006	32. Registrar's Stonature	and .		,	

			For State Registrar		State	of Ma	aryland /				lealth a Death		ental Hy	gien Reg. N	e 200	06	29366
			1. Decedent's Name	(First, Middle,	Last)								2. Date of De	eath			3. Time of Death
	Physici /Medio		Mary M	argare	Heaco	ock							Month Septem				9:29P M
	Examir		4a. Fecility Name (If	not institution,	give street and	number)			4b. City	Town, or	Location	of Death		ac of Death the Day Year tember 7, 2006 9:29P M  4c. County of Death Montgomery  of Birth, Day, Year)  . 31, 1923 9. Birthplace (State or Foreign County)  . 31, 1923 New York  10g. Citizen of What Country?  United States  sor Note.  14. Race - American Indian, Black, White, etc.  Specify: White  16b. Kind of Business/Industry  Mass Transit  Middle, Maiden Sumame)  anlon  Number, City or Town, State, Zip Code)  ge Park, Florida 32003  11, Silver Spring, Marylan  Home, Bethesda—Chevy Chase, Inc. esda, Maryland 20814  Approximate Interval Between Onset and Death  Years  23d. Date of delivery Chase, Inc. esda, Maryland 20814  Years  23d. Date of delivery Chase, Inc. esda, Maryland 20814  Years  23d. Date of delivery Chase, Inc. esda, Maryland 20814  Years  24b. Were autopsy findings available prior to completion of cause of death?  1 yes 2 No 3 Probably 4 Unknown  Years  24b. Were autopsy findings available prior to completion of cause of death?  1 yes 2 No 3 Probably 4 Unknown  Residence 6 Other (Specify)  Scribe how injury occurred			
1			Suburba	n Hosp	ital				Ве	ethes	da				Montg	ome	ry
	Funeral Director		5. Social Security Nu 094-14-58	1	6. Sex 1 □ M 2 🔼		(In yrs. last	birthday) Yrs.	If Unde Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D. Jan. 3	rth ay, Year	923	Cour	itry)
	P _		Usuel Residence of I														
	arylar	_		10b. County			10c. City, To	own or Lo	ocation							1	
	Ba-f	cto	Maryland	Montgo	omery		Bet	hesd									
	or 2	Dir.	10e. Street and Num		,	11005			- 1	Code							,
	death with the Maryland me 23a or 28a-f ehow r must be notified at	ig.	4853 Cor	dell A				T : -		0814							
	er de	nue	11. Marital Status		Amed	Forces?	Ever in U.S.	13.	Was Dece If Yes, spe	dent of Hi cify Cuba	ispanic Ori n, Mexicar	igin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	0-			
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J.	of He Item	4.5	20a. Method of Dispo				20b. Place	of Dispo	osition (Na	me of other plac	e)   C	Senten	ber 11,	20c. L	ocation · C	ity or To	wn, State
Ĕ	Page Dent Ont: If		1 🖾 Burial 2 🗆 4 🗆 Donation 👙			om State		leaven			200		Silver Spring, Maryland  Home, Bethesda-Chevy Chase, Inc.				
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or iteme 23a or 28a-f show amy injury or other traumatic event, the Madical Examinating matter notified at ODGs.		21. Signature of Fun	n	icansee umsme	5	M01173	R	Name a Obert	nd Addres A. Pu	s of Facility mphrey	Tune	ral Homo Bethesda	e, Be	Mass Transit aiden Sumame)  City or Town, State, Zip Code) ark, Florida 32003  Oc. Location · City or Town, State ilver Spring, Maryland  Bethesda—Chevy Chase, Inc. Maryland 20814  Approximate Interval Between Conset and Death  Years		
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	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Medical	29a. Certifier (Check only 2 one)	Ted Certifying ☐ Medical E	xaminer: On th	the best of e basis of nanner sta	examination.	ige, deat and/or in	n occurred vestigation	at the time n, in my or	ne, date an pinion, dea	id place, a th occurre	and due to the ed at the time,	cause(s date an	s) and manr id place, an	er as st d due to	ated. the cause(s)
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State of Maryland / Department of Health and Mental Hygiene 2006 29367 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 2006 SEPT. 11, **Physician** JOHN GILBERT HESTER 4:30 PMM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 338 S. LEHIGH STREET BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | AUG . 1, 1950 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2□F 56 MD. 212-56-6402 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ?? ie marked other than "natural", or Items 23e or 28e-f ehow traumatic event. De Medicul Examinar must be notified at BALTIMORE 1 X Yes 2 No Director MD. N/A 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 UNITED STATES 338 S. LEHIGH STREET Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2√ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) SECURITY OFFICER and Mental Hygie permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 Ie marked othn eny injury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be LOUISE BROWN GILBERT HESTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GLENN HESTER/BROTHER 480 HOLLOW RD., STEWARTSTOWN, PA. 17363 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XX remation 3 ☐ Removal from State 9.13.06 BALTIMORE, MARYLAND METRO CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) CHARLES S. ZEILER & SON, INC. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 4109 23a. Part1. Enter the disease on complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List and one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiomyopathi **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that but to the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the co Due to (or as a consequence of): Examine ed by the attending physicien and detached for use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal de 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 A Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? (es 2 No certificate 1 Yes 2 No 1 ☐ Yes : After this certific funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient ၉ 2 ER/Outpatient 3 DDA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No I Director: A 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature, and title of certifier, RES-000 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eastern Avenue Baltimore, MD 21224 4940 Nkiruka Ohameje 31. Date filed (Month, Day, Year) SEP 1 5 2006 egistrar's Signature Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Reg. No. 2006 29368 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Lawyer Irbv Sept. 13 2006 7:45 A. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Future Care Lochearn Baltimore City N/AIf Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, June 8, Birthplace (State or Foreign Country) **Funeral** 1914 1 X M 2□ F Months Days Hours 215-16-9895 92 Yrs Director South Carolina Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits "naturai", or iteme 23a or 28e-f ehow the Medical Examiner must be notified at 1XXYes 2 □ No Director Maryland N/A Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3910 Bareva Road 21215 United States death Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status be filed within 72 hours after 1 ☐ Yes 2 🛣 No ff Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Black þ 3 ☐ Widowed 4 1 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. important: if item 27 ie marked other than "na any injury or other traumatic event, the Mades ones. Elementary/Secondary (0-12) Coltege (1-4or 5+) MD Drydock Welder N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Irby Mary Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Whitehead (Niece) 3910 Bareva Road, Baltimore Maryland, 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Evans Funeral Chapel Sep. 14, 2006 Forest Hill, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation
2325 York Road, Timonium Maryland, 21093 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fige.

Immediate Cause (Final ACULL) MCCQ Valial Mal of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Compliance of Comp Approximate Intervat Between Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner whete Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) burial-Box 68760. attending physicien for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) P.O. I signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Yes 2 Probably 4 □Unknown should a Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has b autopsy performed 1 ☐ Yes 2 No 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: Swithin 24 hours after death.
To the Funeral Director: After this certifical 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 2 No 2 1 Tyes 1 🗌 Inpatient Number S ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA After thi funeral o 28a. Date of Injury (Month, Day Year) 28b. Time of Injury eath 27. Manne 28c. fnjury at Work? 28d. Describe how injury occurred Certification: 5 Pending T-Natural s after dec. investigation 1 Tyes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier npletely (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 9/13/06 D26748 been 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) n Dr. Anil Uberoi 4419 Falls Road, Suite A, Baltimore Maryland, 21210 32, Registrar's Signature 31. Date filed (Month, Day, Year) SEP 1 5 2006 Registrar

		1 - For State Registrar	State of Ma	aryland	l / Depa <i>Cer</i>	ırtmen <i>tificat</i>	t of H e of L	ealth a Death	ınd M	lental Hyg	iene2	006	2936
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within 2 To the	×	29b. Signature and title of certifier		TUMP,		Au	License		181		_	ned (Month, Wbev	Day, Year) +, Zexce
Sta Registr		30. Name and address of person who Away STump  31. Date filed (Month, Day, Year)  SEP 1 5 2001	22 S. 9	neene	v, de		of Su	ugen	<u> </u>	BOTTIME	one M	DZIZ	01

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 29370 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Martha M. Jones 09 04 2006 1:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Holy Cross Hospital Silver Spring If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 07-31-1913 Birthplace (State or Foreign Country)
 FL 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF 93 Director 266-12-6918 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Itam 27 is marked other than "natural", or Itams 23a or 28a-f ahow other traumatic avent, the Modical Examinar must be notified at 1 ☐ Yes 🙀 🔀 No Director DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 904 Shepherd Street NW 20011 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: Black þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Unknown unknown Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benjamin Wiggins Rose Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9107 Apalachee Pkwy, Tallahassee, FL 32311 Lossye White/Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ital
any Injury or ott to Burial 2 ☐ Cremation 3 ☐ Removal from State 9-19-2006 Arlington, VA 4 □ Donation 5 □ Other (Specify) Arlington National 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licenses 4217 9th St NW, Wash DC 20011 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shark, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Gastrointestinal Bleeding Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine tending physicien and Due to (or as a consequence of): attending physicien by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4 Pregnant at time of death 5 Other (specify) cete hes been signed by the a page 2 should be detached 9□ Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1 Yes 21 No 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) Hospital: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 ☐ Yes 2 🔀 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeret Director: 6 Could not be determined 3 🖺 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a, Certifier 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D52261 09-06-06 Va. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan R. Segal, MD 1517 Hugo Circle, Silver Spring, MD 20906 A. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registra

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death with the Maryland

filed within 72 hours after

The law requires that the death certificate be executed

To the Hospital or Attanding Physician:

death.

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State of Maryland / Department of Health and Mental Hygiene 29371 Amend item#19b, perFH, G859, 9/15/06 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** SEPTEMBER 13 2006 KESNER SYLVIA 12:03 AM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE UNION MEMORIAL HOSPITAL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 02/21/1917 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2□F Yrs. 219-42-7670 89 MD Director Usuel Residence of Decedent the Marylend 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Show BALTIMORE BALTIMORE MD 1 ☐ Yes 2 No Director r than "natural", or items 23s or 28s-f: the Medical Examiner must be notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1450 BEDFORD AVENUE #503 21208 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Naver Married 2 ☐ Marriad Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 No Specify: Specify: 2 3 ₩ Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry permit. Pages 1 end 2 should be filed within Depertment of Heelth and Mentel Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) BANK TELLER 12 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Surname) Be ALBERT **SCHERMAN** FANNIE **SCHOEN** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 5 STAG LEAP COURT - BALTIMORE, MD 21208

20b. Place of Disposition (Neme of cemetery, cremetory or other place)

Date 20c. Location - City of Course of Cemetery, cremetory or other place) GERALDINE BROWN / DAUGHTER 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) BALTIMORE HEBREW CONG. 09/14/2006 REISTERSTOWN, MD 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. **Physician** tmmediate Cause (Final disease or condition resulting in death) /Medical Pulmonary MINUTES Examiner Examiner slcien end buriel-transit death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieled events resulting in death) Last Due to (or es a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significant conditiona contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Diarrhea ģ 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Completed After this certificate has 1 TYes 1 ☐ Yes 2 ☐ No completely filled in by the funerel director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one. Hospital: 1 ☐ Inpatient 2 ► ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Naturel 2 Accident 5 Pending investigation efter deeth. 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 6 To the Hospital within 24 hours e TE Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00061199 Sept, 13,2006 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) Jason Black, Suite 209, Touson mo) 6565 North Charles ST, 32. Registrer's Signature 31. Date filed (Month, Day, Year) SEP 1 5 2006 Registrar

DHMH 16 Rev 6/95

ORIGINAL

		State of Maryland / Department of Health and N  State Certificate of Death  For State Registrar	Mental Hygie	ene2006	29372
Physicia	n	1. Decement's Name (First, Middle, Last)  Kendena Aisha / ee	2. Date of Death Month	Day Year	3. Time of Death
/Medica Examine		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Death	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign
Director	4	Usual Residence of Decedent	1-2Z	79 May	y land
aryland ehow	2	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 □ Ves 2 □ No
ith the M or 28a-1	recto	10e. Street and Number 10f. Zip Code	10g	. Citizen of What Cou	
eath wi	Funeral Director	4722 ELISON AUGULL 2/206  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	pecify Yes or No-	USA 14. Race · Ameri	can Indian
033 urs :	2	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Si If Yes, specify Cuban, Mexican, Puerto Yes, Give Year or Dates:  13. Was Decedent of Hispanic Origin? (Si If Yes, specify Cuban, Mexican, Puerto Yes, Give Year or Dates:	n Rican, etc.)	Black, White	
21215-0036 d within 72 hours all giene. In a matural; or in the Maddell Exemi	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work (ife. DO NOT use retired)	king 16	b. Kind of Business/Ir	idustry
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re, Maryland :  re, Maryland :  1 and 2 should be filed 1 Health and Mental Hyg 1 them 27 is marked othe other traumatic event,	1	19a. Informant's Name/Relationship (Type, Print furents)  19b. Mailing Address (Street and Number or Ru  Kenneth/ee4Vonnie/eeEdwards 3113 Gibbons A	ral Route Number, C	City or Town, State, Zi	) 10 1 4
more, M		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20	c. Location - City or T	own, State
~~ 프 · 트립승 ·		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Ligensee  22. Aame, and Address of Facility	16/06	301to 1	21(0)
Ba Permi Depa Impo eny ii		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode obgoing, such as cardiac	oud Pa	Cto. MD:	21212 Approximate
Physician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	or respiratory arrest		Interval Between Onset and Death
/Medical Examiner		resulting in death)  Due to (or as a consequence of):			
De is	lner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury)			
	Examiner	resulting in death) Last  C.  Due to (or as a consequence of):			
68760, rificate be ex	edical	d			
Box 66 eath certific attending p	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of deliv	ery Day Year
P.O. I that the de ed by the a detached f	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown			
cords, F wrequires the been signed should be de	d by F	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.  A NOXIC BRAIN INTURY		co use contribute to t 2 ☐ No 3 ☐ Pro	
ecor law req as beer 2 shou	plete	DIABETES	24a. Was an autopsy	24b. Were auto	opsy findings available ompletion of cause of
Vital Rodician: The decision: The Pector, page	a l	HYPERTENSION  25. Was case reterred to medical  26. Place of Dec.	performe	d? death? INo 1 ☐ Yes	
Division of Vital Records, P.O. Box or or Attending Physician: The law requires that the death certaire death.  Director: After this certificate has been signed by the attending in by the tuneral director, page 2 should be detached for use	10 B	examiner?  1  Yes 2 No	ome 5 Residenc	ce 6 □Other (Speci	fy)
tision of the diagram of death. Ctor: After th	ation	11☑Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
Divis	Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	et and Number or Run State)	al Route Number,
Division of Vital Records, P.O. Box 6  To the Hospital or Attending Physician: The law requires that the death certifit within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director. page 2 should be detached for use as	edicai C	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and place and manner stated.	, and due to the caus rred at the time, date	se(s) and manner as s and place, and due t	itated. o the cause(s)
To th withir To th comp	M	29b. Signature and title of certified MD 29c. License number RES 000	7	Date signed (Month,	0000
3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRIYANICA SOIN, 5601, LOCH RAVEN BL  31. Date filed (Month, Day, Year) SEP 1 5 2006  32. Registrar's Signature	VD BA	ITIMO	2006 PF MD-21
State Registra		31. Date filed (Month, Day, Year)  SEP 1 5 2006  32. Registrar's Signature	, , ,		-39
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	Funeral			. Sex 7. / 1 X M 2 ☐ F		last birthday)	If Under Months	1 Year Days	If Under 2 Hours	Min.	B. Date of Bir (Month, Da	th y, Year)	Co	thplace (State or Foreign
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8	ral', o	l by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates			1 ☐ Yes 2	No No	Specify:			S	pecify: Cau	ıcasian
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Ba	Dep Impe		May	8							Balti			21224
П			23a. Part1. Enter the disease, or co shock, or heart failure. List	motications that caus ly one cause on each	ed the death line	n. Do not ent	er the mode	of dying	g, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between
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В	/Medical Examiner		resulting in dealin,	Due to (or a	is a consequ	uence of):								241
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ox (	death certifical e attending phy d for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom								23	d. Date of deli	iverv
m	0 0 0	icia	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant	at time of de		]Ectopic pre ] Other (spe						Month	Day Year
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	requires that the reen signed by th hould be detache	þ	Part II. Other significant conditions	contributing to death	but not resu	ulting in the u	nderlying ca	iuse givei	n in Part I.					the cause of death?
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Vital	an: Ti	a	25. Was case referred to medical						26 Place	of Death	Check only o	2 No	1 🗆 Yes	2 No
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Division	al or Attend after death Diractor: d in by the f	Certification:	4 Homicide determine	d 28e. Place of I	njury - At ho etc. <i>(Specif</i> y	me, farm, str	eet, factory,	office		28	City or Tox		Vumber or Ru	iral Route Number,
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	To tha within 2.	Med	29b. Signature and title of certifier	and manner	stated.			License					signed (Month	
	7		1 Juna	Munn	rec	SiClent		Rec	s C	000		Sent	mbes	13 2m/
	H		30. Name and address of person wh	o completed cause of	death (Item	23a) (Type,	Print)	100	s C			STATE	~ 1 1 1 1 1 1 1	13,2006
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DHMH 17 Rev 1/2001

Physician /Medical Examiner 4s 4s 4s 19 19 19 19 19 19 19 19 19 19 19 19 19	Decedent's Name (First, Middle, Las Mary Ann McCorma  a. Facility Name (If not institution, give Gilchrist Center)  Social Security Number  216-42-6591  Jeual Residence of Decedent  Oa. State  10b. County  Maryland  Baltimo  Oe. Street and Number	ck street and num	7. Age (In yrs.		4b. City,	Town or		Se		Day 13, 20	3. Time of Death
Director	Social Security Number 6. Security Number 216-42-6591 1  Sual Residence of Decedent 10b. County 10b. Maryland 10b. Maryland 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10b. County 10	ex :		1		Tows		Death		4c. County of D	oeath timore
	0a. State 10b. County  Maryland Baltimo		63	last birthday) Yrs.	If Under Months		If Under 24	Hrs. 8. Da Min. Ma	ate of Birth fonth, Day, Ye	ar) 9.	Birthplace (State or Fore Country) Aryland
rer must be rer must be uneral Di		re	10c. Cit	y, Town or Lo	cation ingho				100	Citizen of What	10d. Inside City Lim 1 Tyes 2 🔯
등급   또	4205 Garland Av  1. Marital Status 1 □ Never Married 2 🖔 Married	12. Was Deced	ces? 2 IX No	81	Vas Deced Yes, spec	lent of His		36 n? (Specify Youerto Rican,		U.S	•
Completed by	3 Widowed 4 Divorced  15. Decedent's Ed (Specify only highest grade) Elementary/Secondary (0-12) 12	If Yes, Give Year or Da ucation de completed) College (1-	tes:	16a. Deced (Give life. L	kind of wor OO NOT us	l Occupa k done di e retired)	iring most o	f working		Kind of Busine	
marked other matic event, III	7. Father's Name (First, Middle, Last)  JOSEPH Frank G  9a. Informant's Name/Relationship (7		ski	Trans			18. Mother's Mary	Soph	ie Weg	grzynia	k
or other tree.	John F. McCormack  Oa. Method of Disposition  1X Burial 2 □ Greenation 3 □	(husba	20b. P	4205 lace of Disposemetery, crem	Garla sition (Nam natory or ot	und A	venue,	, Nott	ingham,	Location - City	1236 or Town, State
E Y	11. Signature of Fundal Service Licent	7	St.		. Name and	d Address	of Facility	Schimu	nek Fui	ltimore neral H MD 2123	
yscien and le burial-transit le burial-transit le burial-transit leal Examiner leal Examiner	st JK, or heart failure. List only of mm inter Cause (Final lisease or condition esulting in death)  Gequentially list conditions, any, bading to immediate ause. Enter Underlying ause. Closease or injury nat initiated events esulting in death) Last	a	0	,	_ C,	anc	el				Interval Between Onset and Death
for use	FFEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		th 2 ☐ Fetal nt at time of de	death 3 🗌	Ectopic pre Other (spe					23d. Date of Month	delivery Day Year
e d d	art II. Other significant conditions co	ntributin <b>g</b> to dea	ath but not resu	ultin <b>g</b> in the un	derlying ca	iuse giver	in Part I.	23	3e. Did tobacc		e to the cause of death? Probably 4 Inkno
ifficete hes	5. Was case referred to medical						26 Place of	10	a. Was an autopsy performed?  Yes 251	prior death	autopsy findings availal to completion of cause of 1? 'es 2 \( \sum \) No
r: After this cer le funeral direct ation: To B	examiner? 1	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home  28a. Date of Injury (Month, Day Year) 28b. Time of Injury (Month, Day Year) 28c. Injury at Work? 28c.							ath Check only one flower (Specify) hospic 28d. Describe how injury occurred		
completely filled in by the funeral  Medical Certification; 7  25  26  27	3 Suicide 4 Homicide 6 Could not be determined	building	of Injury - At ho	r)	Section 1 is	entra el co	data and	Cit	ly or Town, Sta	ate)	Rural Route Number,
To the Fune completely fill	(Check only one) 2 Medical Example one) 9b. Signature and title of certifier	nor: On the bas and manne	sis of examinater stated.	ion and/or inv	estigation,	in my opi	nion, death on the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the	and during at the	29d. C	Date signed (Mc	onth, Day, Year)

			For State Registrar		State of Ma	aryland /	Departm Certific				Reg. No		29375
	Physici	an	1. Decedent's Name							2. Date of D Month	Da		3. Time of Death
	/Medi		FRANCES			AEL				09	13	2006	
	Examir	ner	4a. Facility Name (If I			01/0	46.0	-	r Location of Deat	h	40	County of Deat	more
			Franklin 5. Social Security Nur			e (In yrs. last	hirthday) If Ut	COSC	If Under 24 Hrs	8. Date of B	dh	Q Rie	
	Funeral Director		2144028 Usual Residence of D	350 ¹	м 215 г	64	Yrs. Mon		Hours Min.		26, 19	942 MA	hplace (State or Foreign untry) RYLAND
	land ow			10b. County	.,,	10c. City, To	own or Location			-,-,-			10d. tnside City Limits
	h the Maryland r 28a-f ehow r notified at	to	MD	BALTIMO	RE	ROS	SEDALE						1 Tes 2 No
	r 28s	Director	10e, Street and Numl	ber			10f.	Zip Code			10g. Cit	tizen of What Co	untry?
	th with	a D	66 K	ING HEN	RY CIRCI	LE		212	37			USA	
5-0036	within 72 hours after death with the Maryland ene. than "natural", or Iteme 23s or 28s-f show he Medical Examinar must be notified at	by Funeral	11. Marital Status 1 □ Never Marrier 3 ☒Widowed 4		2. Was Decedent Ramed Forces? 1 Yes 2 2 1 If Yes, Give Year or Dates:	Ever in U.S. No		s 2 No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)	0-	14. Race - Ame Black, White Specify: WI	
5-0	72 ho	ted	(Specifi	15. Decedent's Educ y only highest grade	cation	16	6a. Decedent's l	Jsuat Occup	ation during most of wo	rkina	16b. K	(ind of Business/	Industry
2121	i within 72 hours liene. r than "natural", the Medical Exa	Completed	Elementary/Second		Cottege (1-4or 5	i+)	life. DO NO		during most of wo	· · · · · · · · · · · · · · · · · · ·	01	WN HOM	F
21	77 15 14 14	S			0			HOM	EMAKER				
P	be fill d off	Be l	17. Father's Name (F STANLEY		DUBIEL				18. Mother's Na	me (First, Middle			NOVOWEVE
3	should be nd Mental marked o	7					01 14 11 4 1	<i>(</i> 2)					NCKOWSKI
, Maryland	is 1 and 2 should be filled if Heelith and Mental Hygitem 27 le marked othe other treumatic event,		19a. Informant's Nan DIANA F	RUTLE					and Number or R ERICK F				21771
Baltimore,	or oth		20a. Method of Dispo	osition ]Cremation 3 □R	emoval from State	сете	of Disposition (	or other plac	79)   DV   0 /1	Date 8/06		ocation - City or	
ξ	tmentant			Other (Specify)		PARI	(WOOD (					FIMORE,	
Bal	permit. Pages 'Department of H Important: If its eny injury or of		21. Signature of Fund	eral Service License	90								NERAL HOME MD 21237
			23a. Part F. Enter the	offernse or comoli	nations that caused	the death D						IMORE,	Approximate
	Physician /Medical Examiner		Immediate Cause (F disease or condition resulting in death)	<b>(</b> *	A 10	puln		4	Arres	+			Interval Between Onset and Death
N.S.	icate be executed physicien and s the buriat-transit	Examiner	Sequentially list conditions, leading to immoduse. Enter Underth Cause (Disease or in that initiated events resulting in death) La	C C	Due to (or as	nes	shrit	S					
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_		/Me	IF FEMALE:	2:	3c. If yes, outcome	of pregnancy						22d Date of deli	
O. Box	or Attending Physicien: The law requires that the death certificate death. Director: Atter this certificate hes been signed by the attending in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent of in the past 12 m 1 Yes 2 9 Unknown	pregnant ponths?	1☐Live birth 4☐Pregnant at 9☐Unknown	2 Fetal dea		c pregnancy (specify) _	1			23d. Date of deli Month	Day Year
ds, P.O	ires that the de signed by the a d be detached t	by	Part II. Other signific	cant conditions con	tributing to death bu	ut not resulting	g in the underlyi	ng cause giv	en in Part I.		tobecco		the cause of death?
Ö	v requir been s should	ete								24a. Wa:		Odb Ware au	toon finding and blo
Rec	The lav	Completed								auto	opsy ormed?	death?	topsy findings available completion of cause of
tal	iclen: T certificel ector, p	0	25. Was case referre	ed to medical					26. Place of De	1 ☐ Yes ath (Check only	20(No	1 ☐ Yes	2 No
<u> </u>	ysicl is cer direc	To B	examiner? 1 ☐ Yes 2 📉 N	lo H	ospital:	nt 2 ER/	Outpatient 3	DOA Oth	00			6 □Other (Spec	cifv)
ō	ding Physicien: h. Atter this certific funeral director,		27. Manner of Death		28a. Date of Injur (Month, Day	ry 288	D. Time of tritury	28c. Injur Wor		28d. Describe			
Ö	Attendin death. ctor; Alt y the fun	atio	1 ⊠Natural 2 ☐ Accident	5 Pending investigation	(Month, Da)	/ rear)	M		Yes 2 □No				
Division of Vital Records,	il or Attence after death Director; d in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Inju- building, etc	ury - At home, c. (Specify)	, farm, street, fac	ctory, office		28f. Location City or To	(Street ar	nd Number or Ru e)	ral Route Number,
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	ledical C	29a. Certifier (Check only 2	Certifying Phys	ician: To the best of eer: On the basis of and manner sta	examination	dge, death occur and/or investiga	red at the tir tion, in my o	ne, date and place pinion, death occ	e, and due to the urred at the time	cause(s , date an	) and manner as d place, and due	stated. to the cause(s)
	omple	Me	29b. Signature and ti	itle of certifier	. 4			29c. Licens	e number		29d. Da	te signed (Monti	h, Day, Year)
	,- > F 0		VA.R.	we then to	I hatta	)		RE	5 000			9/13/06	
			30. Na and ad	ss of person who co	mpleted cause of de	eath (Item 23a	a) (Type, Print)					.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	6		Diz Joseph i	المحدال بالدياث	elroath 9	000 Fra	nklin Sa	vare i	Drive B	altimor	e M	laryland	21237
	Sta	ate	31. Date filed (Month	n, Day, Year)	32. Begistra	ar's Signature		4			·····		
	Regist	rar	S	Day, Year) EP 1 5 200	6 Steeles	n B	Book	2					

DHMH 17 Rev 1/2001

State Registrar a role Milher

SEP

5 2006

31. Date filed (Month, Day, Year)

MO

9.00S.C 32. Régistrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

ave BALTIMOR

			State of Maryland / Department of Health and Mental Hygiene 1- State Registrer  Certificate of Death Reg. No. 2006 29377
	Physici /Medic	cal	1. Decedent's Name (First, Middle, Last)  Eloise K Marshall  2. Date of Death September 07 2006 4:35 PM
	Examir Funeral Director	ner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death  7. Age (In y/s. last birthday)  1 M 2 D F  86 Yrs.  4b. City, Town, or Location of Death  1 M 2 D F  4c. County of Death  1 M 2 D F  9. Birthplace (State or Foreign Months Days Hours Min. August 6, 1920 Mary Land
	ס		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	with the Ma a or 28a-f	Director	MD Howard Columbia  10e. Street and Number  10f. Zip Code 10g. Citizen of What Country?
36	it. Pages 1 and 2 should be filed within 72 hours after death with the Maryland sitned of Health and Mental Hygiene. It after 15 a marked other than "natural", or items 23a or 28a-f show njury or other traumatic event, the Medical Examinational be notified at a njury or other traumatic event, the Medical Examinational be notified at	by Funeral	9418 Dartmouth Rd.  21045  USA  11. Marital Status  1
Maryland 21215-0036	within 72 hou lene. than "natura the Medical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  12  Legal Secretary  Law Firms
yland 2	should be filed ind Mental Hygi marked other umatic event,	To Be Co	17. Father's Name (First, Middle, Last)  Thomas Krears  18. Mother's Name (First, Middle, Maiden Sumame)  Madolin Rayfield
	s 1 and 2 sh f Health and Item 27 is m other traum		19a. Informant's Name/Relationship (Type, Print)  19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Mrs. Janet M. Collins / Daughter 9418 Dartmouth Rd.; Columbia, Md. 21045  20b. Place of Disposition (Name of Disposition County)  20c. Location - City or Town, State
Baltimore,	permit. Pages Department of I Important: if Itt any njury or o		1 Darial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  National Memorial Park 9/11/06  Falls Church, VA.  21. Signature of Funeral Service Licensee  Page 17. Signature of Funeral Service Licensee  22. Name and Address of Facility Everly—Wheatley Funeral Home
	Physician		23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition on the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the conditio
8760,	/Medical Examiner  hysician and the burial-transit	dicai Examiner	Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):
.O. Box 6	ath certifi ttending i or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
ords, P.	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Winknown
Vital Records,		e Completed	Dement a 24a. Was an autopsy findings available prior to completion of cause of death?  1 Yes 2 No 1 Yes 2 No
Division of Vit	ing After unei	ToB	25. Was case referred to medical examiner?  1
DIVI	To the Hospital or Attend within 24 hours after death To the Funeral Director: / completely filled in by the f	cal Certification:	3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier 29a. Certifier 29a. Certifier 29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	To the Hor within 24 h To the Fur completely	Medical	(Check only one)  2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)
1	) (		30. Name and address of person who completed cause 1d ath (Item 23a) (Type, Print)  Ming Vi 3320 15-4 NGM Avenue, Bultimore Maryland 21227
	Sta Registr		31. Date fill d (Mrnth, Day, Year) SFP 1 5 2006 32. Registrar's Signature

			1 - For State Registrar	State of M	aryland	•	artment			d Menta		ne No.2001	6 29378
	Physicia		1. Decedent's Name (First, Middle,	Grace A.	Mi11	er				Mor	of Death	Day Yea	3. Time of Death
)	/Medic Examin		4a. Facility Name (If not institution, s				4b. City,		ocation of D	eath		4c. County of De	
	Funeral Director		5. Social Security Number 141–18–5240	Sex 7. Ag	ge (In yrs. la 84	as <i>t birthday)</i> Yrs.	If Under Months	1 Year	If Under 24 I	Hrs. 8. Date Min. (Mor Augus	of Birth oth, Day, Yes	9. B	dirthplace (State or Foreign Country)  W Jersey
	ed et	٥٢	Usual Residence of Decedent  10a. State 10b. County  Maryland Montg	omery	10c. City	, Town or Lo	cation kvi11	е					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the had a or 28a-	Direct	10e. Street and Number 4412 Cherry Val				10f. Zip	Code 20853				Citizen of What C	·
350	should be filed within 72 hours after deeth with the Maryland and Mental Hygiene.  marked other then "neturel", or items 23a or 28a-f ehow umatic event. Ite Medical Examinar must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces?	?		Was Deced f Yes, spec		Danic Origin's Mexican, Pi Specify:	? (Specify Yes uerto Rican, e			nerican Indian, nite, etc.
9500-61212	I within 72 hou iene. r then "neture the Medical E	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		5+)	(Give life.	dent's Usua kind of wor DO NOT us Lions	k done du e retired)	ring most of	working		Kind of Busines	Sovernment
yland	uld be filed Aental Hyg rked other tic event.	To Be C	17. Father's Name (First, Middle, La Orville Anderso:	*	1			1		Name (First, I	Middle, Maid	·············	
Σ	end 2 should half and N		19a. Informant's Name/Relationship Thomas 0. Mille			4412	Cheri	cy Va	11ey I			y or Town, State ille, Ma	Zip Code) aryland 20853
Baitimore,	permit. Pages 1 end 2 should be Department of Health and Menta Important: If item 27 ie marked eny injury or other traumatic ev once.		20a. Method of Disposition 1   Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		'	ace of Dispo emetery, crei emont				eptembe 16, 200	er	Location - City of semont,	or Town, State New Jersey
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	Physician /Medical		23a. Part1. Enter the disease, or or shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	nly one cause on each li	ine. imer	Demen		of dying,	such as car	diac or respira	atory arrest,		Approximate Interval Between Onset and Death Years
08/00,	rate be executed XX hysicien and XX the burial-transit	icai Examiner	Sequentially list conditions, lary leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as  c. Due to (or as  d.	Armin's								
O. Box 6	eath certific ettending p tor use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic pre Other (spe			-		23d. Date of d Month	lelivery Day Year
cords, P.	w requires that the di been signed by the should be detached	þ	Part II. Other significant condition	s contributing to death b	out not resu	Iting in the u	nderlying ca	iuse given	in Part I.	236	Did tobacc		to the cause of death?  Probably 4 Unknown
Ž	The la ete has page 2	Completed								_	. Was an autopsy performed Yes 2 🔀	prior to death	autopsy findings available o completion of cause of 7
VII	sicien: certific rector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatie	ant 0 -	ER/Outpatier	• • • • • • • • • • • • • • • • • • • •	100-		Death (Check	1 1	a 2011 - 10	
lon of	D 0 0	ation: To	27. Manner of Death  1 XNatural 5 Pending 2 Accident investigat	28a. Date of Inju (Month, Da		28b. Time of Injury		Bc. Injury a Work?	4 M Mulsin			6 ☐Other (Sp	oecity)
DIVISION	- 0 -	Certification:	3 Suicide 6 Could no 4 Homicide determin		jury - At hor tc. (Specify)	me, farm, str	eet, factory,	, office			ation (Street or Town, St		Rural Route Number,
	To the Hospital o within 24 hours ett To the Funeral Di completely tilled in	edicai	29a. Certifier 1  Certifying (Clock unity one)	Physician: To the best tarriffer: On the basis o and manner st	of examinati	vledge, deat ion and/or in	occurred a vestigation,	at the time in my opir	, date and pl	lace, and due occurred at the	to the cause time, date a	(s) and manner and place, and d	as stated. ue to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	_			- 1	License r			29d. I	Date signed (Mo	nth, Day, Year)
	10/	1	30. Name and address of person with	> no completed cause of c	death (Item	23a) (Tyne		00556	94			Septembe	er 12, 2006
	14		Alok Mathur, M.	D. 4000 01	lney I	Layton	svill	e Roa	d, 01:	ney, Ma	arylan	d 20832	
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 5	2006 32. Registr		ure A	and i						

DHMH 17 Rev 1/2001

			1 - For State Registrar	State	of Maryla		artment of I rtificate of				giene Reg. No.!	7111	06	29379
			1. Decedent's Name (First, Middle	e, Last)					2	2. Date of De	ath Day		Year	3. Time of Death
	Physici: /Medic			Rose	Mermels	stein			5	Septem				4:58 PM M
	Examin		4a. Facility Name (If not institution	, give street and n	umber)		4b. City, Town,	or Location	of Death		4c.	County o	f Death	
			Suburt	an Hospi	tal			Bethe	sda			M	ontg	omery
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🗓 F		rs. last birthday)	If Under 1 Year Months Days		Min.	3. Date of Bir (Month, Da	v. Year)	1	9. Birthp	lace (State or Foreign
	Director		206-26-8015	I∐M 2001E	88	Yrs.			M	larch 3	, 19	18	Czec	hoslovakia
	and *		Usual Residence of Decedent  10a, State 10b, County		10c.	City, Town or Lo	ocation						1	0d. Inside City Limits
	Aaryl Feho	ō	Manual and Ma					Rockv	4110					1 X Yes 2 ☐ No
	the t	rect	Maryland Mo	ntgomery			10f. Zip Code	ROCKV	TTTE		10g. Citi	zen of Wi	hat Cour	ntry?
	3a or	□	6111 Mont	roge Dec	a #617			2085	.0					States
	me 2:	Funeral Director	11. Marital Status	12. Was De	cedent Ever in	1 U.S. 13.	Was Decedent of If Yes, specify Cut			ify Yes or No	-	14. Race	- Americ	an Indian,
0	or ite		1 ☐ Never Married 2 ☐ Marr	ied 1 Tyes	2 X No					ican, etc.)			, White,	etc.
3	rei', c	by	3 X Widowed 4 ☐ Divorced	If Yes, C Year or			1 ☐ Yes 2 🗓 No	Specify:				Specify:	W	Mhite
ה ה	be filed within 72 hours after death with the Maryland that lygiene. Id other then "natural", or iteme 23e or 28e-f ehow other then "natural", or iteme 20e or 28e-f ehow event, the Mudical Exercities raise the natified at	Completed	15. Deceden (Specify only higher	t's Education	f)	(Give	dent's Usual Occu	during mos	st of working	2	16b. Ki	nd of Bus	iness/Ind	dustry
V	ithin	ďμ	Elementary/Secondary (0-12)	1	(1-4or 5+)	life.	DO NOT use retire	∍d)		,				
V	led w lygier her th		8	/			Seams	stress		Con Middle				ndustry
מ	be fi	Be	17. Father's Name (First, Middle,	ŕ	_			18. MOIN	·	First, Middle,				
2	should nd Men marke umatic	٤	19a. Informant's Name/Relations	Moshe R	oth	405 14-11	4 4 4 /0			Faige/				0. (1.)
	12 st h and 7 te n traun						ng Address (Stree							,
ນ	Heelth Heelth tem 27 other tra		Ruth F. Kirsche 20a. Method of Disposition	enbaum/ Da		D. Place of Dispe	08 Fox Ho	OTTOM	Road,			_		Wn, State
5	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Department of Heelth and Mental Hygiene. Important: if item 27 is marked at Hygiene. Important: if item 27 is marked at the than "naturel", or iteme 23s or 28s-f show may injury or other traumatic event, the Maclical Examiner mast be inclifted at ance.		1 X Burial 2 ☐ Cremation		n State	cemetery, cre	matory or other pla	,	Sept	ember				
	it. P.		4 □ Donation 5 □ Other (S		MC	ount Sin	ai Cemete	ery	12,	2006	Lake	Wood	, Ne	w Jersey eral Home/
Ö	permit. Departimportimport			7/	+ 2000	B	ethesda-(	Chevy	Chase	Inc.	755	7 W1	scon	eral Home/ sin Avenue
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	MOO		ethesda, ter the mode of dy					-		Approximate
			shock, or heart failure. List Immediate Cause (Final	only one cause on	each line.									Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		oke o (or as a cons	sequence of):							-	24 Hours
	Examiner					1 Infar	ction							24 Hours
		ē	Sequentially list conditions, if any, leading to immediate	U	o (or as a cons		CCION						-	24 Hours
1	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a Acı	ite Art	erial I	schemia l	Leg						72 Hours
o O	an an rial-tr	Exa	resulting in death) Last		o (or as a cons									
00/0	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dlcal		d										
Ď	ng pt	Ved	IF FEMALE:	T							1			
Š	w requires that the death certific been signed by the atlending f should be detached for use as	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?		utcome of pre-		⊒Ectopic pregnanc	су			2	23d. Date Mont		ery Day Year
5	e des the a	sic	1 □Yes 2 No 9 □ Unknown	4□ Pre-	gnant at time o nown	of death 5	Other (specify)					IVI GITT		Day Tour
ŗ	hat the d by detac		Part II. Other significant condition	one contributing to	death but not	reculting in the I	indochring cause a	won in Part	1	23e Did t	obacco u	se contrib	bute to th	ne cause of death?
S,	signe d be o	ģ	Tarris, Ottor significant contains	on contributing to	doath out not	resulting at the c	indenying cause gi	IVOIT IIIT CIT	••	1	Yes 2	_		ably 4 Unknown
cords,	peen	etec												
ě	hysician: The law his certificate has b I director, page 2 s	Completed								24a. Was autor		pr de	ere auto ior to cor eath?	psy findings available inpletion of cause of
	n: Tł ficate f, pa		no Managara de madia							1□ Yes	2 <b>∑</b> No	1(	∃Yes	2 No
VII	sicta	Be c	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No	(Janaital.	npatient 2	2 ☐ ER/Outpatre		hor		Check only o	-			
5	Phy r this aral d	2	27. Manner of Death		e of Injury onth, Day Year		11 3L 100A	4 🗆 141		e 5 Resi				Y)
0	ding th.: Afte	텵	1 X Natural 5 ☐ Pendin 2 ☐ Accident investi	9	onth, Day Year	r) Injury		ork? ]Yes 2. [	]No					
VISION	Attended of the by the	ifica	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 286. Pla	ce of Injury - A	t home, farm, st	reet, factory, office	,	28				r or Rura	l Route Number,
5	s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s afte	Certification:	4 [] Hornicide	Duli	ding, etc. (Spe	<i>вспу)</i>				City or To	wii, State,	,		
	To the Hospital or Attending Physician: within 24 hours alter death. To the Funeral Director: After this certifics completely filled in by the funeral director,		29a. Certifier 1 Certifyir	g Physician: To t Examiner: On the	he best of my l	knowledge, deat	th occurred at the t	ime, date ar	nd place, an	nd due to the	cause(s)	and man	ner as st	ated.
	the H in 24 the F	Medical	one)	and ma	anner stated.	III ation and or ii		_	aur occurre	zat tile tittle,				
	To To	2	29b. Signature and title of certifie	( )	1		29c. Licen	ise number			29d. Dat	e signed	(Month,	Day, Year)
	/		Cotun	WH	Ver	206		D390	64		Ser	temb	er ]	11, 2006
	15		30. Name and address of person	1	-			20/ -	) = c1 '	11	fo1	01	2005	() )1/)
	Sta	10	James Salande 31. Date filed (Month, Day, Year)		Registrar's Si		e Pike #	ZU4 1	KOCKV1	TTE, N	aryl	.and	2085	02-3143
	Registr		SEP 15	i i	106.10	K A	metel							
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DHMH 17 Rev 1/2001

			For State Registrar	State of Marylan				lealth and Death		giene Reg. No.	)6	29380
3	Physici		Decedent's Name (First, Middle, Last)	C	M				2. Date of De Month	Day	Year	3. Time of Death
	/Medic Examin		William  4a. Facility Name (If not institution, give s	S. treet and number)	Murra		Town, or	Location of Dea	<u>Septemb</u>	er 8, 20		8:30 P ^M
1	8		1281 Bartonshire				omac			Montg		
	Funeral Director		150-18-9128	M 2□F 7. Age (In yrs. 80	last birthday) Yrs.	Months	1 Year Days	If Under 24 Hr Hours Mir	. (Month, Da	rth ay, Year) 5, 1926	Country	
	Maryland a-f ehow	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Montgome:	-	y, Town or Lo	cation					100	d. Inside City Limits 1 ☐ Yes 2 ☐ No
	or 284	Oirec	10e. Street and Number			10f. Zip				10g. Citizen of W	hat Country	y?
	sath w	erai	1281 Bartonshire	Way 12. Was Decedent Ever in U.	S 13 1		0854	isnanic Origin? (	Specify Ves or No	United	State	
036	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Ifean 27 is marked other than "naturel" or items 23s or 23s-1 ehow other traumatic event, it a Micipal Exeminar must be notified at	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Amed Forces?  1X Yes 2 No Wor If Yes, Give Year or Dates: War	ld	f Yes, spe		Specify:	Specify Yes or No rto Rican, etc.)	Black Specify:	k, White, etc	C.
2-0	72 ho 'natur	eted	15. Decedent's Educ (Specify only highest grade		16a. Dece (Give	kind of wo	rk done o	durina most of w	orking	16b. Kind of Bus	siness/Indu	stry
121	within ene.	du	Elementary/Secondary (0-12)	College (1-4or 5+) 5-1-		earcl		) ientist		Federal	Gove	rnment
d 2	e filed within al Hygiene. I other than vent, Ite Mi	Be Co	17. Father's Name (First, Middle, Last)	٠	Reb	caro			ame (First, Middle	, Maiden Sumame		
/lan	2 should be and Mental is marked o	To B	William Murray					Maria	n Sparro	W		
Maryland 21215-0036	12 shoul h and Me 7 is mari raumati		19a. Informant's Name/Relationship (Typ			3	. –			er, City or Town, S		
	Health tem 27 other tr		Doris Q. Murray/W 20a. Method of Disposition	20b. P	lace of Dispo	sition (Na.	me of		, Potoma	c, Maryl 20c. Location - C		20854 n, State
OM			1 ☐ Burial 2 ဩ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Mon	emetery, crer itgomer matori	У	_	Şer	tember 2006	Bethesd	a. Ma	rvland
Baltimore,	permit. Page Depertment of Important: If eny injury or once.		21. Sign two SE is ral Service License	90 MOO	803 Be	Name as	nd Addres da-Cl	ss of Facility R nevy Cha Maryland	obert A. se, Inc. 20814-3	Pumphre 7557 Wi 3501	y Fun scons	eral Home/ sin Avenue
	200		23a. Part1. Enter the disease, or complication shock, or heart failure. List only on	cations that calised the deat	h. Do not ent	er the mod	de of dyin	g, such as cardi	ac or respiratory a	rrest,	í.	Approximate nterval Between Onset and Death
*	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Pancreas C								Shock and Boath
	Examiner			Due to (or as a conseq	uence of):							
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of):							
7	be executed ician and burial-transit	Examiner	cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of):							
8760,	cate be executed obysician and the burial-transit	ical E	L _a	l								
9	artifical ing phy e as th		IF FEMALE:									
P.O. Box	The law requires that the death certificate has been signed by the attending places 2 should be detached for use as it	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	death 3	∃Ectopic p ∃ Other (s)				23d. Date Mon	of delivery th D	/ Day Year
	quires that n signed build be deta	þ	Part II. Other significant conditions con	ntributing to death but not res	ulting in the u	nderlying	cause giv	en in Part I.		tobacco use contri Yes 2 ∑ No		cause of death?
Records,	The law require ete has been sig page 2 should b	Completed							24a. Was auto perf 1 ☐ Yes	psy pr ormed? de	rior to comp eath?	sy findings available pletion of cause of
Vital		Bec	25. Was case referred to medical examiner?						eath (Check only			
of	Phys	ion: To	1 ☐ Yes 2 ☒ No H  27. Manner of Death 1 ☒ Natural 5 ☐ Pending	lospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury		28c. Injun Wor	4 🗆 Rursing		idence 6 Othe		
Division	E ta C e	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, str y)					(Street and Number wn, State)	r or Rural I	Route Number.
	To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by th	edical (	29a. Certifier 1 Certifying Physical (Check only one)	sician: To the best of my knower: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred vestigation	at the tin	ne, date and pla pinion, death oc	ce, and due to the curred at the time	cause(s) and man date and place, a	ner as stat nd due to t	ted. he cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of sertifier	1-1				e number	_	29d. Date signed		
}	(.1		6/080				ノし	19655		9-12	-06	0
1	54		30. Name and address of person who co				oad.	N.W., 1	Vashingt	on, D.C.	2000	07
· A	Sta		31. Date filed (Month, Day, Year) SEP 1 5 20	32. Registrar's Signa	ture							
É	Registi	rar	25 2 2 2 2 2 2 2 2	106 Alexano	15. 1	234/	1					

		1	For State Registrar	State of Marylar		artment of H tificate of L		lental Hygi ®	ene g. N $2006$	29381
	Physicia		1. Decedent's Name (First, Middle, L	1St) M 401	1	-		2. Date of Death Month	Day Yee	1 5 7/11
	/Medic Examin		4a. Facility Name (If not institution, g.	ive street and number)		4b. City, Town, or	Location of Death	1/10	4c. County of De	
	Lamin	C1	UNION MEMORIAL H	OSPITAL		BALTI	MORE		N/A	
	Funeral Director		5. Social Security Number 6. 215-28-4439	Sex 7. Age (in yrs.	last birthday) 74 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, AUG 8 1	Year)	lirthplace (State or Foreign Country) MARYLAND
	and w		Usual Residence of Decedent  10a, State 10b, County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	Maryta f sho	ō	MARYLAND N/A		RΛ	LTIMORE				1XXXYes 2 ☐ No
	n 18e	Director	10e. Street and Number		<u>DA</u>	10f. Zip Code		10	g. Citizen of What	Country?
	23a c	aiD	3000 REISTERST	OWN RD APT 82E		212			U.S.A.	
	er dea Itams	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. \	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puert	pecify Yes or No- p Rican, etc.)	14. Race - Ar Black, W	nerican Indian, hite, etc.
36	within 72 hours after death with the Maryland ene. than "natural", or itams 23a or 28e-f show the Mayleal Examinar must be notified at	by F	1 ☐ Never Married 2 ☐ Married  3 ※ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1□Yes 2ĀNo	Specify:		Specify: B	LACK
9	72 hou	ted	15. Decedent's (Specify only highest of	Education	16a. Deced	dent's Usual Occupa	ation furing most of work	kina 1	6b. Kind of Busines	ss/Industry
21	nithin 7 ne. han "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use retired	)		DD TIII	m D
2	Hygie Hygie ther t		12th grade  17. Father's Name (First, Middle, La.	st)	STEEL	WORKER	18. Mother's Nam	ne (First, Middle, N	PRIVA faiden Sumame)	TE
an	ld be ental kad o ic eve	To Be	SAMUEL MYERS				PAULI	NE MYERS		
Maryland 21215-0036	d 2 should be filed within h and Mental Hygiene. 7 is marked other than "traumatic event, the Mer	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailin	ng Address (Street a	and Number or Ru	rai Route Number,	City or Town, State	n, Zip Code)
ک ش	permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural," or items 23a or 28e-f show any injury or other traumatic event, the Marical Examinar must be notified at once.		Reginald Allen/	Nephew		Alto Bd.	, Baltim		yland 212	
Jor	ages int of h		1 XBurial 2 ☐ Cremation 3	☐Removal from State	cemetery, crer	natory`or other plac	1			
Baltimore,	nit. Partme orteni injury		*4 □ Donation 5 □ Other (Special Signature Pungfal Servi Lice		22	DGE CEMET  . Name and Addres	s of Facility			, MARYLAND
B	Depa Impo any is		13/52			ILLIAM C 206 W NOR			FUNERAL H	OME P.A.
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	hi and cause on each line						Approximate Interval Between Onset and Death
H	Pnysician		Immediate Cause (Final disease or condition resulting in death)	a Cardia	c A	rhyth	mia			
	/Medical Examiner		- C-1990 O	a. Cardia  Due to (or as a conse	quence of):	Card	iovas	culer !	ligono	
		ner	fany, leading to immediate cause. Enter Underlying	b. Dust to (or as a conse	quence of):				Jugary	
	ecuted and transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a conse	avance of).					
8760,	the death certificate be executed y the attending physician and tched for use as the burial-transit	al E		L .	quarica or).					
9	ificate g phys as the	edicai		d						1:20
Вох	eath certific attending p	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr 1☐Live birth 2☐Fet		Ectopic pregnancy			23d. Date of Month	delivery Day Year
	ne dea the at hed fo	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	death 5□	Other (specify)			Worter	ody rour
P.O.	es that the digned by the be detached		Part II. Other significant conditions	contributing to death but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?
rds	w requires been sign should be	ed by						1 ☐ Ye	s 2 No 3	Probably 4 Dunknown
Vital Records,	S 5	ompleted						24a. Was ar autops	y prior	autopsy findings available to completion of cause of
al R		O							1 U Y	
Zit.	Physician: This certificate ral director, p	o Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2	JER/Outpatier	nt 3 DOA Oth	00	th (Check only one	nce 6 □Other (S	nacify)
10		-	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		y at	28d. Describe ho		peony
sior	ending I sath. or: After he funer	atio	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could no	ion	,,		Yes 2 □ No			
Division	s after death. I Director: After al in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine		home, farm, str cify)	reet, factory, office		28f. Location (Sti City or Town		Rural Route Number,
_	To the Hospital or At within 24 hours after or To the Funarel Direct completely filled in by			Physician: To the best of my kr						
	tha Ho in 24 h iha Fu ipletely	edicai	one)	aminer: On the basis of examinand manner stated.						
	To To con	Σ	29b. Signature and title of certifier	0.		29c. Licens			9d. Date signed (Mo	ontn, Day, Year) ≉
,	15		30, Name and address of person wh	no completed cause of death (Its	/1. 12. em 23a) (Tvne	Print)	1703		1112/06	
	6		LIADAT AL	1 821 N-E	intaw	st. E	Baltin	re MI	) 2/20/	
	Sta Regist		31. Date filed (Month, Day, Year) SEP 1 5	and manner stated.  And completed cause of death (Ite  1 82   N = E  2006  32. egistrar's Sign	nature	reste				

2006 29382 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** ALEXANDER MYERS RUSSELL 9 6:05 pM 2006 September /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner GILCHRIST CENTER FOR HOSPICE CARE BALTIMORE TOWSON | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | OCT 9 1924 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** XXM 2□ F MARYLAND Vrs 217-18-0091 Director 81 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. fnside City Limits 7 is marked other than "natural", or items 23e or 28e-f show traumatic event, the Madical Examinat must be notified at 1 ☐ Yes 2 ☐ XNo Director BALTIMORE MARYLAND BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21162 U.S.A. 331 LORELEY ROAD Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 Never Married 2 X Married XYes 2 No If Yes, Give Year or Dates: 50/51 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "ray Injury or other traumatic event, the Med and june. Elementary/Secondary (0-12) College (1-4or 5+) LAFAGE SOOT OPERATOR 7th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be FANNIE MYERS JOHN MYERS 19a. Informant's Name/Relationship (Type, Print) 19b. Maifing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores C. Myers/Wife 331 Loreley Rd., Baltimore, Maryland 21162 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09-15-06 OWINGS MILLS, MARYLAND GARRISON FOREST 21. Signature of Funeral Service Consee 22. Name and Address of Facility WM C BROWN COMMUNITY FUNERAL HOME-HARFORD, 321 S PHILADELPHIA BLVD., ABERDEEN MD 21001 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Prostate Physician (ancer 4005 /Medical Due to (or as a consequence of): Examiner Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner led by the attending physician and detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetaf death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ You 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No After this certificate has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certilica Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) VIOSCICO 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

DHMH 17 Rev 1/2001

State Registrar

Medical

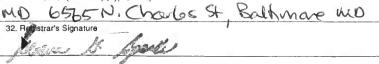
(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 5 2006

M. Gordan

30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)



MD

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

00051926

29d. Date signed (Month, Day, Year)

Sept 10

		For State Registrar	State of Marylan		artment of F			ene <b>20</b> 66 a. No.	29383
Physici		Decedent's Name (First, Middle, La:     MARCIANN		XWE	=/1		2. Date of Death Month		3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give	strept and number)	SPITAL		TIMO	RE	4c. County of Dee	th
Funeral Director		5. Social Security Number 6. S 213-05-6088 1  Usual Residence of Decedent	ex □ M 2ÅF 7. Age (In yrs. 86	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, ) Dec16, 1	1919 Ma	thplace (State or Foreign buntry) ryland
Be-f show	Director	10a. State 10b. County  Md. Balti		y, Town or Lo	lea		1		10d. Inside City Limits 1 ☐ Yes 2 ☒ No
s 23a or 2 rust be n		10e. Street and Number 21 Fuller Ave	nue	6 40		1206		g. Citizen of What Co USA 14. Race - Ame	
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. I and Mental Hygiene is an extend other then 'neturel', or items 23a or 28e-1 show is marked other then 'neturel', or items 23a or 28e-1 show reumatic event, it a Madical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ℃ Widowed 4 □ Divorced	Armed Forces?  1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 X No	Specify:	o Rican, etc.)	Black, Whit	
within /z m iene. rthen "netu ine Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		(Give life.	dent's Usual Occup kind of work done DO NOT use retired Maker	during most of wor	rking	6b. Kind of Business  Own Hor	
uld be riled Aental Hyg rked other tic event, i	To Be C	17. Father's Name (First, Middle, Last, Francis Ference					ne <i>(First, Middl</i> e, <i>Ma</i> Modrak		
and 2 sho ealth and N m 27 Is ma		19a. Informant's Name/Relationship (Melinda Sudano	-Daughter	21	Fuller A		Baltimor		Land21206
permit. Pages 1 and 2 should be liled within 72 in Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "netur eny injury or other treumatic event, It a Mcdeal once.		20a. Method of Disposition  1 □ Burial 2 □ X Dremation 3 □  4 □ Donation 5 □ Other (Specification of Funeral Service Lice)	Removal from State Bay	yview yview 22	2. Name and Addre	ory $9-1$	l-2006 B zorowski		e, Marylan L Home,PA
Physician /Medical Examiner I pontial-Itansil	Examiner	23a. Part1. Enter the distance, or come shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of the consequence)  Due to (or as a consequence)  Due to (or as a consequence)	uence of):  Diffuence of):			RCTIC		Approximate Interval Between Onset and Death
attending physor use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of degree Unknown	Ideath 3	□Ectopic pregnanc: □ Other (specify) _	y	, F	23d. Date of de Month	ivery Day Year
w requires that the deben signed by the should be detached	þ	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	inderlying cause giv	ven in Part I.		acco use contribute to	the cause of death?
ine law requisate has been page 2 shoul	Completed						24a. Was an autopsy performs	prior to	utopsy findings available completion of cause of
Pnysicien: In rithis certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1  Yes	Hospital: 1 Inpatient 2  28a. Date of Injury	ER/Outpatier	f 28c, Injur	ner: 4 □ Nursing H	ath (Check only one) ome 5 Residen 28d. Describe how	ce 6 □Other (Spe	cify)
To the Hospitel or Attending Physicien: into 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Certification:	1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined		Injury ome, farm, st		rk?  Yes 2 □No	28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
Hospitel 24 hours at Funerel E stely filled i	edicai Ce		ysician: To the best of my kno niner: On the basis of examina and manner stated.						
To the Vithin To the Comple	Med	29b. Signature and title of certifier	Ball, M		29c. Licens	5891	3 SE	d. Date signed (Mont	R 8 2006
4		30. Name and address of person who	completed cause of death (Item	n 23a) (Type,	Print) 560	Loca	1 RAVEN	V BOUL	EVARD

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

SEP 1 5 2006

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, <-

32. Registrar's Signature

			For State Registrar	State of I	Marylan	id / Depa <i>Cei</i>	artment of H	ealth an Death	d Menta	ıl Hygier Reg. 1	/ 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	29384
	Physici		1. Decedent's Name (First, Middle Gisela		(	Ormsby			Mo	e of Death onth [	Day Year 11, 2006	3. Time of Death
	/Medio Examin		4a. Facility Name (If not institution, 11800 Nebel Str		er)		4b. City, Town, or Rockvi	11e	Death		tc. County of Death Montgome	
	Funeral Director		5. Social Security Number 225-74-6965 Usual Residence of Decedent	6. Sex 7. 1 ☐ M 2 1 F	Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Dat Min. (Mo June	e of Birth inth, Day, Yea 29, 19	9. Birth Cou 937 Gern	place (State or Foreign intry) nany
	e Maryland ta-f ehow	ctor	10a. State 10b. County  Maryland Montgo	omery		y, Town or Lo						10d. Inside City Limits 1∑Yes 2 ☐ No
	h with th	ai Dìre	10e. Sireet and Number 402 Broadwood D	rive			10f. Zip Code 20851				Citizen of What Cou	,
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23e or 28e-f ehow entry injury or other traumatic event, the Madical Exemple rotal be notified at once.	by Funerai Director	11. Marital Status  1 □ Never Married 2 ☒ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force ed 1 Tyes 2[ If Yes, Give Year or Date	s? XNo		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2X No	spanic Origin n, Mexican, P Specify:	? (Specify Ye Puerto Rican,	s or No- etc.)	14. Race - Amer Black, White Specify: W	
Maryland 21215-0036	i within 72 ho jiene. r then "natur ine Medical	Completed	15. Decedent (Specify only highest Elementary/Secondary (0-12)		or 5+)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired iistrative	luring most of )		Αι	Kind of Business/li itomobile alership	ndustry
yland ?	l Mental Hyg I Mental Hyg Parked other	To Be C	17. Father's Name (First, Middle, L Herbert Thomse	n				Gertr	rud Kat			
, Mar	and 2 st salth and n 27 Is n		19a. Informant's Name/Relationsh William A. Orm			402	Broadwood	d Drive			or Town, State, Zi Marylan	
Baltimore,	Pages 1 nent of He ant: If Iter ary or oth		20a. Method of Disposition 1 ☐ Burial 2 🖔 Cremation 4 ☐ Donation 5 ☐ Other (Sp		10		sition (Name of natory or other place Crematorium	1 -	tember 2006		Location - City or T :hesda, Ma	
Balt	permit. Departr Importu eny inji		21. Signature of Funeral Service L	4 / / 4	M011	.73   ²²   R	Name and Address obert A. Pi 00 W. Mont	s of Facility Imphrey gomery A	Funeral Avenue,	Home,	Rockville, le, Marylan	Inc.
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or candidate cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	a. Mult Due to (or		fyeloma		j, such as car	rdiac or respir	atory arrest,		Approximate Interval Between Onset and Death
> ,09289	icate be executed physicien and s the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a conseq	uence of):						
.O. Box 6	The law requires that the death certific sie has been signed by the atlanding p bege 2 should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcor 1  Live birth 4  Pregnant 9  Unknowr	2 ☐ Feta at time of d	Ideath 3	Ectopic pregnancy Other (specify)				23d. Date of deliv Month	өгу Day Year
rds, F	w requires that been signed should be det	Þ	Part II. Other significant condition	s contribuling to death	but not res	ulting in the ur	ndertying cause give	n in Part I.	23	e. Did tobacco	o use contribute to t 2 X No 3 ☐ Pro	he cause of death? bably 4 Unknown
al Reco	: The law re icele has ber r, pege 2 sho	Completed							_	a. Was an autopsy performed? Yes 2\(\Delta\)	prior to co death?	opsy findings available impletion of cause of
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The lay within 24 hours after deadh. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ation: To Be	25. Was case referred to medical examiner?  1 💆 Yes 2 🗎 No  27. Manner of Death 1 💆 Natural 5 🗀 Pending investig:			ER/Outpatien 28b. Time of Injury	28c. Injury Work	r: 4 🗆 Nursin			6 XOther (Speci ury occurred	y) Scene
Divis	s after deat al Director: ed in by the	Certification:	3 ☐ Suicide 6 ☐ Could no determine	286. Place of	Injury - At ho etc. (Specify	ome, farm, stre	eet, factory, office			ation (Street or Town, Sta	and Number or Run te)	al Route Number,
	To the Hospital or within 24 hours after to the Funeral Director Completely filled in Its	edicai	29a. Certifier 1  Certifying (Check only one)	Physician: To the be xaminer: On the basis and manner	of examina	wledge, death tion and/or inv	occurred at the tim restigation, in my op	e, date and pl inion, death o	lace, and due	to the cause e time, date a	s) and manner as s nd place, and due t	stated. o the cause(s)
)	To t Com	Σ	29b. Signalone and title of centifier	(b) 74	١,		29c. License DO	number )63385			otember 1	
	10		J. A. Farillo,				Print) sin Avenu	ıe, Bet	hesda,	Mary1	and 2088	39
	Sta Registr	_	31. Date filed (Month Par Year)	2006 32. <b>G</b> gi	strar's Signa	turk: A	alli					

	_	= State Registrar		State			rtificat	te of L	Death				. No.C	106		385
sicia	ın	Decedent's Name (First		.ast)							2. Date of Month		^{Day} 2006	Year	3. Time o	
edic	al -	Doris Obin 4a. Facility Name (If not in		ive street and n	(mber)		4h City	Town or	Location of	of Death	Sept.	9,		ty of Death	11:00	)III ''
mine	er	Stella Mar		770 Sil 001 Mil 770			Timo		2002.1011	, = 0				imor		
ral		5. Social Security Numbe		Sex	7. Age (In yrs.	last birthday)	If Unde Months	r 1 Year	If Under Hours	24 Hrs. Min.	8. Date of	of Birth	/earl	9. Birth	nplace (State	or Foreig
or		220-07-744	8	1□M 2∏F	86	5 Yrs.	Months	Days	Hours	WIIII.	Mar.	26,	1920	Mar	yland	
	-	Usual Residence of Dece 10a. State 10b.	. County		10c. Ci	ity, Town or Lo	ocation								10d. Inside C	ity Limi
	ě		ltimo	**		nonium									1 🗆 Yes	
	Director	10e. Street and Number	LLIMO	16	III	ionitum	10f Zir	p Code				10	g. Citizen o	f What Cou	untry?	
		2300 Dulan	ey Va	lley Roa	ad		1	21093	3				J.S.A.			
	Funeral	11. Marital Status		12 Was Dec	edent Ever in I	J.S. 13.	Was Dece	dent of Hi	spanic Ori	gin? (Sp	ecify Yes o	r No-			ncan Indian,	
	F.	1 Never Married 2		1 Tes	orces? 2000 ive		1 ☐ Yes	37	n, mexicar Specify:		rtican, etc	.,		ack, White	o, etc. ucasiar	1
	d b	3 ₩ Widowed 4 □ E	Divorced	If Yes, G Year or I	Dates:		1 103	263110					Зрес	ny.		
	Completed		Decedent's nly highest g	Education grade completed,	)	16a. Dece (Give	dent's Usu kind of wo DO NOT u	al Occupa	ation during mos	t of work	kin <b>g</b>	1	6b. Kind of	Business/I	ndustry	
	mp	Elementary/Secondary 12th grade	(0-12)	College	(1-4or 5+)	Homen		ise retirea	)			(	Own Ho	me		
	ပို	17. Father's Name (First,		st)		Homen	diction		18. Mothe	er's Nam	e (First, M.		aiden Suma			
	To Be	John Doher									hardt					
	F	19a. Informant's Name/F	Relationship	(Type, Print)		19b. Maili	ng Addres	s (Street a	and Numbe	er or Rui	ral Route N	umber,	City or Tow	n, State, Z	ip Code)	
		William Ob	inger	, son		5324	Glen	thorr	ne Co	urt,	Rose	dal	e, MD	212	37	
	- 1	20a. Method of Disposition			1	Place of Dispo	osition (Na	me of	<b>a</b> )		Date	2	oc. Location	n - City or T	Town, State	
		1XXBurial 2 □ Cre 4 □ Donation 5 □ 0			State	ardens	-			ept	13. 2	006	Bal	Ltimo	re, Ma	rv1
gi	1	21. Signature of Funeral	Service Lic	ensee	, 00										Home,	
900		/ wy	Cu.	2							Balti			212		
		23a. Part1. Enter the dis	sease, or co ure. List on	mplications that	caused the dea	th. Do not on									Approxima	te
٦	0	In-madista Course (Final			each line.	iii. Do not en	ter the mod	de of dyin	g, such as	cardiac	or respirate	ory arres	st,	ì	Interval Be	ween
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achary Pazui		State of Maryland / Departme	ate of Death		g. No. 2006	29381
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Wedical Examini		Zachary Allen Pazur  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
	Į.	Woodrow Wilson Bridge	Fort Washington	-1	Prince George	
Funeral Director		5. Social Security Number  489-96-2538  1 X M 2 F 21  Usual Residence of Decedent	hday) If Under 1 Year If Under 24Hrs  Months Days Hours Min  Yrs.	_	h (MM/DD/YYYY) 9. Birti Foreigi 3,1984 Cou	
any		10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limits
Maryland 28a-f show 4 at once.	į	MO St. Louis St. Lo				1 Yes 2 X No
th the Maryland 23a or 28a-f sho totified at once.	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Coun	try?
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at <u>once</u>		5006 Lenox Avenue  11. Marital Status 12. Was Decedent Ever in U.S.	63119  13. Was Decedent of Hispanic Origin? ( S			ean Indian, Black,
or item	Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	
ırs after ural", miner	اھ	Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed) 16a.	1 Yes 2 X No specify:  Decedent's Usual Occupation (Give kind of	work done	Specify: Whi	
72 hou	etec		during most of working life. DO NOT use ret	ired)		
15-0036 filed within 72 hours after a Il Hygiene ed other than "natural", o t, the Medical Examiner	Completed	1.2 17. Father's Name (First, Middle, Last)	Framer 18.Mother's Name	e (First Middle M	Constructi	.on
21215-0036 Juld be filed within 7 Mental Hygiene marked other than cevent, the Medica	Be C	Stephen T. Pazur, Jr.		. Wester		
21. hould be nd Mer is mar		19a. Informant's Name/Relationship (Type, Print )	b. Mailing Address (Street and Number or		•	Zip Code)
nore, MD 2 ages 1 and 2 shou nt of Health and N t: If item 27 is n other traumatic	H	20a. Method of Disposition 20b. Place of	522 Weil Ave., St.	Louis, M	0 63119 20c. Location - City or	Town, State
more, MD 21215-0036 Pages I and 2 should be filed within 72 nent of Health and Mental Hygiene unt: If iten 27 is marked other than " or other traumatic event, the Medical I		A Bullar 2 Cremation 3 Removal from State	ory or other place)  cordia Cemetery 9-	-11-06	St. Louis,	MO
Baltimore, permit. Pages I an Department of Her Unportant: If ite Important or other tr	t	21. Signature of Funeral Service License	22. Name and Address of Facility Ku	tis Fune	ral Home-Af	ton Chapel
Physician	\$	23a Part I. Enter the disease, or complications that caused the death. Do no	10151 Gravois Rd.			123 Approximate Interval
/Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a Sharp Force Injuries to the c				Between Onset and Death
Examiner		or condition resulting in death)  Due to (or as a consequence of):				
	اچ	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):				
	Examine	(Disease or injury that initiated events resulting in death) Last			,	
760, ficate be executed g physician and s the burial - transit		d				
60, ate be ex hysician	Medical	UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome of pregnancy	<u></u>		23d. Date of delivery	
6876 ertifical ding ph		23b. Was decedent pregnant in the past 12 months?	process of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the sam	ancy	1	ay Year
Box 687 e death certific the attending p	ysician/	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)			
that the detected by the	by Phy	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I.		bacco use contribute to	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death.  The Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.	tedk			1 Yes		ably 4 Unknown
cords,	Completed			autop: perfor	med? death?	ompletion of cause of
/ital Rec ysician: The linis certificate		25. Was case referred to medical	26.Place of Death (Check	1 Yes 2 only one)	2 No 1 Ye	s 2 No
Vita hysicia this ce	To Be	Yes 2 No			Residence 6 🗸 Other	Scene
in of ading Ph.		1 Natural 5 Pending FOUND: Day, Year) FOL	Time of Injury 28c. Injury at Work?  JND: 1 Yes 2 No		now injury occurred bed and cut self	
/iSiO	ficat	2 Accident Investigation Sep 5, 2006 1300	O hrs arm, street, factory, office building, etc.		Street and Number or Ru	ral Route Number, City
Div spital o	Certification:	4 Homicide determined (Specify) car		or Town, S Woodrow W	rate) /ilson Bridge, Fort '	Washington, MD
	Medical	29a. Certifier (Check only one) 2 Certifying Physician: To the best of my knowledge, decone) 2 Medical Examiner:On the basis of examination and/or i and manner stated.	nvestigation, in my opinion, death occurred		and place, and due to the	e cause(s)
	Σ	29b. Signature and title of certifier	O.C.M.E.		29d. Date signed (Mor September 6, 20	
J.		30. Name and address of person who completed cause of death (Item 23a)  Zabiullah Ali, M.D. Assistant Medical Examiner 1	11 Penn Street, Baltimore, MD 2	1201		
Str	ate	24 Date filed (Marth Day Vers) 22 Beforetrarie Signature				
Regist		APD 4 6 7000 7 7 11 2%	Sperie			,

Rico	Antonio	Ramos-Collazo
VICO	MILOINO	Mailios-Odiazo

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar		,	Cer	tificate of	Death		, , ,	Reg	g No. 2	00	6 2938
Physician Medical Examine	•	Name (First, Middle,	_{-ast)} on <b>i</b> o	Ramos-	-Collazo	2			Date of Death Month September			3 Time of Death 0152 hrs
-		ame (if not institution,				lb City, Town, c	r Location o		epterriber	4c County o	f Death	
) 1	5 Social Seci	re Washington N		. Age (In yrs. la	net hirthday)	Glen Burni		r 24Hrs 8	Data of Buth	Anne Aru		pplace (State or
Funeral Director	220 <b>-</b> 75		XM 2 F	O O	Yrs.	Months Da		7		2, 2006	Foreign	
any	Usual Reside 10a. State	nce of Decedent 10b. County		10c. City,	Town or Locati	on			_			10d. Inside City Limits
<b>*</b> .	Marylar	nd Anne A	runde1	Sev	/ern							1 Yes 2 XNo
ith the Maryland 23a or 28a-f show notified at once.	10e. Street ar					10f. Zip Code			10	g. Citizen of Wh	at Coun	try?
s 23a o e notifi	1812 11. Marital Sta	Falcon Co		dent Ever in U	S. 13. Was	21144 Decedent of H		in? (Specif	y Yes or No-	USA 14 Race	- Americ	can Indian, Black,
er death with to or items 23a r must be not	1 X Never	Married 2 Marr	1 Yes	ces? 2 X No	If Ye	es, specify Cuba	n, Mexican,	Puerto Rica	an, etc )	White	, etc	
ns after ural".	3 VVIdow	ved 4 Divor	or Dates:	completed)		Yes 2 N				Specify:  16b Kind of Bus		
-0036 within 72 hour giene her than "natu . Medical Exan	Elementary	//Secondary (0-12)	College (1-4			ost of working life				Too Tall of Bac		radion y
5-003( led within Hygiene other tha the Medic	N/	A Jame (First, Middle, La	net)		N/A	A	18 Mother's	s Name (Fir	et Middle M	N/A		
21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica	7	known)	331)					,	Chris	,	o11a	azo
b 21 should and Me 7 is man	-	t's Name/Relationship	, ,,		10					per, City or Town	, State,	Zip Code)
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene inter of Health and Mental Hygiene inter If item 27 is marked other than "natural", or items 23a or 28a-fisher other traumatic event, the Medical Examiner must be notified at once To Re Commisted by Finneral Director	20a. Method			20b F	Place of Disposi	Falcon (	emetery,			20c. Location -	City or 1	rown, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural". Unjury or other traumatic event, the Medical Examiner To Ro Completed by		2 Cremation on 5 Other Spec		n State Lou	rematory or oth idon Pat	ck Cemet	ery	9/14/	06	Baltimo	re,	Maryland
Baltimo permit. Pag Department Important: injury or ot		of Funeral Service Li								k Funer		
Physician		nter the disease, or co		used the death.						ore, MD st, shock, or hea		Approximate Interval
/Medical Examiner	Immediate Ca	ist only one cause or ause (Final disease		mexplain	ed death	in infan	СУ					Between Onset and Death
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Division of Vital Records, P.O. B rat or attending Physician: The law requires that the d its after death  al Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached	5	significant condition	is contributing to t	leath but not re	sulting in the u	nderlying cause	given in Par	it I.				ably 4 🗸 Unknown
Records, The law requires froate has been significate has been significant beautiful by			<u> </u>						24a Was ar autopsy			opsy findings available ompletion of cause of
Recol The law cate has l							_		perform 1 <b>Y</b> Yes 2	ned? de	eath?	
Vital Recysician: The libit certificate burector, page	25 Was case examiner?		Hospital:	nationt 2	ER/Outpatient		e of Death (			Residence 6	Othor	
of V ing Phys After thi uneral di	27 Mannar of		28a Date of (Month, D		28b. Time of Ir		ury at Work?			ow injury occurre	Other	
sion attendin death ctor: // y the fu	1 Natura 2 Accide	o rendin	g Fnd 9,	/8/2006	Fnd 1:30	-	Yes 2 X	<u> </u>	nknown			
Division or strending ocurs after death neral Director: After filled nu by the fune.	3 Suicio	determ	not be		ome, farm, stree at home	t, factory. office	building, etc	28f.	Location (Strong States)  or Town, States  evern, M	reet and Number ate) 1812 Fa 10	r or Rura <b>1con</b>	al Route Number, City Court
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 34 hours affor death  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans.  Martical Certification: To Re Completed by Physician/Martical E-		1 Certifying Phys	sician. To the best ner: On the basis of	examination ar				ce, and due	to the cause	(s) and manner a		
To Wiff	29b. Signature	e and title of certifier	and manner sta	ited		29c Licen	se number			29d Date signe	d (Mon	th, Day Year)
		4	M. //	t		O.C	.M.E.			September	9, 200	06
	30 Name and Jack Tit	address of Jerson with tus MD. Depu	no completed cause ty Chief Medica			n Street, Ba	ltimore, N	/ID 2120	1			
Stat		(Month Pay Year) 5	2006 32 Re	istrar's Signatu	re K							
Registra	ш	V41 +	1	The state of the state of	6							

			For State Registrar	State of Ma	ryland / [	)€·	nent of F	lealth and Death	Mental I	Hygier	2006	29388
ŧ	ALL S		Decedent's Name (First, Middle, Las.)	0			700.0		2. Date o	Death	Day Year	3. Time of Death
_	Physici /Medio	_	JRVIN		BINJ	0			SE (	7 /1	2006	7-30PM
7	Examir	er	4a. Facility Name (If not institution, give				4b. City, Town, o		ath		4c. County of De	ath TIMORE
	Funeral	2.5	BRIGHTWOOD GARDE 5. Social Security Number 6. Se	x 7. Age	(In yrs. last bir	thday)	If Under 1 Year	If Under 24 H	rs. 8. Date o	Birth		irthplace (State or Foreign
	Director			^{™ 2□ F}	94	Yrs.	Months Days	Hours M	0470	Birth Day Yes 9/191	2	MD
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Lo	cation					10d. Inside City Limits
	Mary a-f sh	tor	MD N/A	1	вА	LTII	MORE					1 Yes 2 □ No
	or 28	Director	10e. Street and Number	IE 001100 ##			10f. Zip Code	-		10g.	Citizen of What C	*
	eath w	erai	4401 ROLAND AVENU	JE CUNDU #2		13 1	21210	dispanic Origin?	(Specify Yes o	r No-	14. Race - Am	
036	72 hours after death with the Maryland "naturel", or iteme 23a or 28a-f show idical Examiner must be notified at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces?  1  Yes 2 No If Xes, Give Year or Dates:			Was Decedent of H f Yes, specify Cub I ☐ Yes 2 X No		erto Rican, etc.	)	Black, Wh	
2-003	72 ho	Completed	15. Decedent's Edi (Specify only highest grad		16a.	Deced (Give	lent's Usual Occup kind of work done	oation during most of v	vorking	16b.	. Kind of Busines	s/Industry
12		iduu	Elementary/Secondary (0-12)	College (1-4or 5+	-)	life. L	DO NOT use retire	d)		50	DINGON I	
0 2	filled Hygi Sther	Be Co	17. Father's Name (First, Middle, Last)	4	0	WNE	К	18. Mother's N	lame (First, Mi			FURNITURE
/lan	0 0 0 0	To B	MORRIS		R	OBI	NSON	JENN]	E		l	LEVENSON
, Maryland	nd 2 s lith ar 27 ts r trau		19a. Informant's Name/Relationship (7 MARJORIE ROBINSON				ROLAND /					Zip Code) ORE, MD 21210
altimore,			20a. Method of Disposition  1 N Burial 2 Cremation 3 4 Donation 5 Other (Specify,		cemete	ry, cren	sition (Name of natory or other pla HEBREW		Date 14/200		Location - City of	
Balt	permit. Pages Department of Important: If i eny injury or one		21. Signature of Juneral Service Licens	100	$\rightarrow$		Name and Address	, 5			& BROS	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused fone cause on each line	the death. Do	not ent	er the mode of dy	ng, such as card	iac or respirato	ry arrest,	ESVILLE	Approximate Interval Between
å	Physician		Immediate Cause (Final disease or condition		anc	20	d de	men	tie			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a								
×		e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence	of):	Ce					aays
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	. La	lune	,	to etc	rive				days
8760,	cate be executed physician and the burial-transit	al Ex	resulting in death) Last	Due to (or as a	consequence	of):						
	tificate I g physi as the b	ledical		d								
XOX	ith cert tendin or use	an/M	JF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome o	f pregnancy	3	Ectopic pregnanc	y			23d. Date of d	
Division of Vital Records, P.O. Box	es that the death certifi gned by the attending be detached for use as	Physician/Me	1 Yes 2 No	4□Pregnant at t 9□Unknown	ime of death	5 🗆	Other (specify)			-	Worth	Day Year
ď.	s that (	by Ph	Part II. Other significant conditions co	ontributing to death bu	t not resulting i	n the u	nderlying cause giv	ven in Part I.	23e.	Did tobacc	o use contribute	to the cause of death?
ords	w require been sig should b								-	¹ □ Yes	2 No 3 1	Probably 4 Donknown
ecc	iawra nas be	Completed							- 6	Was an autopsy	prior to	autopsy findings available completion of cause of
a H	n: The								1 🗆 Y	es 2		s 2 No
=	eicier s certif	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	it 2□ER/Ou	itoatien	t 3 DOA Ott	nor /	eath (Check o		6 □Other (Sp	nacifu)
יסר	ng Phy ter this neral c	n: T	27. Manurer of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day		Time of					njury occurred	Belly)
Sio	eath. or: Af the fur	catic	2 Accident investigation 3 Suicide 6 Could not be				M 1	Yes 2□No				
DIX	el or At s after d il Direct id in by	Certification:	4 Homicide determined	28e. Place of Injur building, etc.	ry - At home, fa . <i>(Specily)</i>	arm, str	eet, factory, office			on (Street r Town, St		Rural Route Number,
	To the Hospitel or Attending Physicien: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical (	29a. Certifier (Check only one) Certifying Physics (Check only one)	ysician: To the best of liner: On the basis of and manner stat	examination an	e, death	occurred at the treestigation, in my	me, date and pla opinion, death o	ace, and due to courred at the t	the cause me, date	e(s) and manner a and place, and di	as stated. ue to the cause(s)
	within Yo th compl	Me	29b. Signature and title of certifier	1			29c. Licens	se number		29d.	Date signed (Moi	nth, Day, Year)
1	7		Syr	) LR MD			Poc	5315	>	SE	27 119	2006
	6		30. Name and address of person who as the filed (Month, Day, Year)  SEP 1 5 2	completed cause of de	ath (Item 23a)	(Туре,	Print)	antr	00 A 800	2d	sut	2110
100	Company of	ate	31. Date filed (Month, Day, Year)	32. Projistra	r's Signature	-/	88 - NO "				7	D 21042
100	Regist	rar	SEP 1 5 2	006	was Si.	S. S. S. S. S. S. S. S. S. S. S. S. S. S	DANS.					

			For State Registrar	State of Maryland /	Depa Cer	rtment of He tificate of D	ealth a Death	nd Mental Hy	/giene2 Reg. No.	006	29389
5	Physicia	an	Decedent's Name (First, Middle, Combine	,				2. Date of D Month	Day	Year	3. Time of Death
3	/Medic	al	Sophia  4a. Facility Name (If not institution,	Romenski		4b. City, Town, or	Location of			1,200	6 12:30A ^M .
*	Examin	er		care-Heritage		Dundal				ltimo	re
18/1	Funeral Director		213-14-8949	6. Sex $1 \square$ M $2 \square$ F $0 1$	birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. 8. Date of B (Month, D Dec13	ay, Year)		place (State or Foreign ntry) yland
	land ow Lt		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Lo	cation					Od. Inside City Limits
	Mary B-f sh	tor	Md. Balt	imore	Dι	ındalk					1 ☐ Yes 2½ No
	or 28	Director	10e. Street and Number		_	10f. Zip Code				of What Cou	ntry?
	eath v	eral	207 Riverview	V AVENUE  12. Was Decedent Ever in U.S.	13. V		222	in? (Specify Yes or N		USA Race - Americ	can Indian.
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 271s marked other then "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	Completed by Funeral	1 Never Married 2 Married 3 Wildowed 4 Divorced	Armed Forces?		Yes, specify Cuban  ☐ Yes 2  ☑ No	Specify:	in? (Specify Yes or N Puerto Rican, etc.)		Black, White, ec <i>ify:</i> Wh	etc.
Maryland 21215-0036	thin 72 ho e. "natur: Medicel	pleted	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	s Education grade completed)  College (1-4or 5+)	(Give	ent's Usual Occupa kind of work done do OO NOT use retired)	uring most	of working	16b. Kind	of Business/In	dustry
2	filed wit Hygiene other the	Con	6th		Hom	e Maker	40 14-15	1- N (5' A4'-2')		wn Hon	ne
and	d be fi	Be c	17. Father's Name (First, Middle, L Frank Procho	•				's Name <i>(First, Middl</i> y Hrapek	e, Maiden Su	mame)	
ary Z	should in Meni	2	19a Informant's Name/Relationsh	in (Type Print)	9b. Mailin	g Address (Street a	nd Number	or Bural Boute Num	ber, City or To	own, State, Zip	Code)
	and 2 ealth a n 27 ls		William F. Pr	ochownik,Jr. 3			Cli				
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 Removal from State ceme	tery, crem	sition (Name of atory or other place	1	Date		ion - City or To	
<u>=</u>	Pa Int	М	4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service L		ed He	Name and Address	SUS S	Sept14,200	Balt:	imore,	Maryland Home, PA
Ba	permit. Departr Importa any inju		- tenbot	locular	1	201 Dun	dalk	Ave. Ba	ltimon	re,Md	21222
	Physician		shock, or heart failure. List of Immediate Cause (Final disease or condition	complications that caused the death. In the complex cause on each line.	one ton of	er the mode of dying	, such as c	ardiac or respiratory	arrest,	6.	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence	e of):	DEM	EN	TIA		9	RYEARS
i i	pe jis	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence	ce of):	AR.	TE	MANI	FAS	F	DYFART
<i></i>	ate be executed hysician and the burial-transi	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequence	ce of):	7/10	IKA	0505	T 10		12/11/13
68760,	ficate be executed physician and s the burial-transi	lcal	11	La ESSEN	17	11+1	4	THER I	ENS	SI DIM	25744
P.O. Box	The law requires that the death certifics to has been signed by the attending phoage 2 should be detached for use as to	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy Other (specify)			23d	. Date of delive Month	ery Day Year
	juires that t n signed by ild be deta	by	Part II. Dther significant condition	ns contributing to death but not resulting	g in the ur	iderlying cause give	n in Part I.		tobacco use		he cause of death?
Records,	The law requir te has been si age 2 should	Completed						24a. Waa auto	opsy formed?	Ab. Were auto prior to co death? 1 ☐ Yes	ppsy findings available mpletion of cause of
ita	cian: ertifica ector, p	BeC	25. Was case referred to hedical examiner?					Obeath (Check only			
o to	Attending Physician: or death. sctor: After this certifics by the funeral director, I	P	1 Yes 20 No		Outpatien		4 Swur	sing Home 5 ☐ Res			(v)
on	th. : After	tlon	1 atural 5 Pending 2 Accident investig	(Month, Day Year)	Injury	28c. Injury Work' M 1 □ Y	?` ′es 2 🗆 N		TIOW INJURY OF	COMPG	
Division of Vital	il or Attsnd after death Dirsctor: /	Certification:	3 Suicide 6 Could n 4 Homicide determi		, farm, stre	eet, factory, office		28f. Location City or To	(Street and Nown, State)	lumber or Rur	al Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best of my knowled xaminer: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the time restigation, in my op	e, date and inion, death	place, and due to the	e cause(s) an , date and pla	d manner as s ace, and due t	stated. o the cause(s)
)	To the	Me	29b. Signature and talle opcertifier	twish mo		29c. License	number 416	50 2	29d. Date s	igned (Month,	Day, Year) 006
	O'I		30. Name afre adjusts of person	rho completed gause of doubth (Itam 43.	a) 1790.	PrintS 410 -	AR	CTCHIE	1410	atthe	AY,
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	RE E		ripy	LIND	( ) dans	2.	

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and M	lental Hygiene
otate of Maryland, Department of Health and M	ionia riygichic

For State Registra 1-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** -06 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner North Bourne 7. Age (In yi Social Security Number 6. *S*ex last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🔀 13-10-542 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at 1 es 2 No Baltimore Director MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or Bourne 2 SA 646N death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 Mo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 5 1 ☐ Yes 2 No Specify Black þ 3 XWidowed 4 ☐ Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 end 2 should be filed within. Department of Health and Mental Hygiene. Important: If them 27 ie marked other than "n. any njury or other treumetin according to the process." Elementa (Secondary (0-12) College (1-4or 5+) COMMUNICATION 0 edhone 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) Be God daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 21239 Baldo ND 20a. Method of Disposition 20c. Location - City or Town, State 3 Removal from State 4 □ Donation 5 □ Other (Specify) Valle 21. Signature of Funeral Service Licensee ieral Services Toad, Bal 21712 to MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respir shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) mer Physician 100 /Medical Due to (or as a consequence of) Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 01 ue to (or as a consequence of) Examine The law requires that the death certificate be executed and Due to (or as a consequence of). O. Box 68760. ettending physicien for use as the buria Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4☐ Pregnant at time of death 5 Other (specify) ed by the e 9 Unknown 9 Unknown Division of Vital Records, P. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an page 2 s autopsy performed certificete 20 No 1 ☐ Yes or Attending Physicien: Medical Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 1 ☐ Yes 2 ☐ 10 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA this Director: After the 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Alatural death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide within 24 hours a To the Funeral C pelli o the Hospitel 1: Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of centifier 29c. License number 29d. Date signed (Month, Day, Year) dem 27+2 106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 670 1 1052 100050 32. Aegistrar's Signature 31. Date filed (Month, Day, Year) SEP 1 5 2006 State SEP 1 B. J. Stant Registrar

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2006 1 - For State Registrar 2939 I Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Schultz, Jr. 6:40 AM Henry 11 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Nursing Center-Towson Baltimore Towson | I OWS UTL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | July 31, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months 1**∑**M 2□F 90 216-07-9247 New York Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at Kingsville 1 ☐ Yes 2X No Director Baltimore Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2. any injury or other traumatic event, the Medical Examples once. 21087 1 Batter Brook Ct. U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specity: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrician Union Local #24 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Louis Henry Schultz, Sr. Alena Catherine Paine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Batter Brook Ct., Kingsville, MD 21087 Patricia Weyant (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State

1 Donation 5 Other (Specify) Entombment Druid Ridge Maus. 9/14/2006 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, MD 233 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction **Physician** /Medical Due to (of as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 25 No 1 ☐ Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 X No 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 1 Certification: 5 Pending investigation 1 Watural 1 🗌 Yes death. 2 No 2 Accident Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 - Homicide within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified HO054424 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cyrus Asadi, 20 E. Timonium rd / Suite #209 Timenium, MD 21093 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 5 2006

			1 - State Amend #29d per Registrar	State of Ma r Phy g859	ryland/	Departm Certific	nent of Ho cate of D	ealth and <i>Death</i>	Mental Hyg	iene 200	6 29392	
	Physici /Medic		1. Decedent's Name (First, Middle, Leet)  2. Date of Death Negth Day (Year G								3. Time of Death	
	Examir		Social Security Number     6. Security Number	sing Cente	nter '. Age (In yrs. last birthday)		4b. City, Town, or Location of De  Catonsville  If Under 1 Year   If Under 24 H  Months   Days   Hours   Mi		s. 8. Date of Birth	4c. County of De Baltim		
	Director Mou		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo			1	110010	April 1	1,1919	Maryland  10d. Inside City Limits	
e, Maryland 2	with the Mar	Director	Maryland Baltimore Catonsville    10e. Street and Number   10f. Zip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g. Cip Code   10g								1 ☐ Yes 2 No	
	be filed within 72 hours after death with the Maryland rial Hyglene. ed other then "natural", or Items 23a or 28a-f ehow event, the Madical Examinar must be notified at	by Funerai	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1  Yes 2 N If Yes, Give Year or Dates:		If Yes,	ecedent of His		Specify Yes or No- rto Rican, etc.)	U.S.A.  14. Race - Ar Black, W		
	e filed within 72 hou al Hygiene. i other then "nature vent, the Medical E	Completed	15. Decedent's Edu (Specify only highest grad	completed) (Give life. D			dent's Usual Occupation kind of work done during most of working DO NOT use retired) OUSEWIfe			16b. Kind of Busine:	ss/Industry	
	2 should be filed and Mental Hygi is marked other aumatic event, is	To Be C	17. Father's Name (First, Middle, Last)  William F. Wright  Eva S.							Thomas  City or Town, State, Zip Code) 21228		
	ealth		19a. Informant's Name/Relationship (Ty Hallie S. Houston 20a. Method of Disposition 1 Burial 2 Cremation 3 F	(Daughte	r) 20b. Place cometo	719 Ma of Disposition ary, crematory	aiden C (Name of or other place	hoice L	ane HR 10	2, Catons 20c. Location - City	ville,Marylan or Town, State	
Baltimore,	permit. Pages 1 Department of H Importent: if ite eny injury or ot once.		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licens	Dam!	(d)			rk   09- s of Facility yniak F rt Aven			ie, Maryland yland 21230	
	Physician /Medical	4	23a. Pen1. Enter the disease, or compi shock, or heart failure. List only of immediate Cause (Final isease or condition resulting in death)	ications that caused no cause on each lin a Due to (or as a	5+	not enter the					Approximate Interval Between Onset and Death	
of Vital Records, P.O. Box 68760,  Physician: The law requires that the death conflicts he executed	cate be executed xxx physicien and multiple burial-transit	dicai Examiner										
	that the death certific ed by the attending p detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								lelivery Day Year	
	w requires that been signed by should be deta	þ	Part II. Other significant conditions con	ntributing to death bu	t not resulting	in the underly	ing cause give	n in Part I.	23e. Did tob		to the cause of death?  Probably 4 □Unknown	
		e Completed	Dr. Wes							ned? death □No 1 □ Y		
	Attending Physician: 1 r death. sctor: After this certifical by the funeral director, p	ToB	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation	1 Inpatier 28a. Date of Injun (Month, Day	y. 28b.	utpatient 3[ Time of Injury	DOA Other	r: 4 Norsing	eath (Check only one)  Home 5 Residence 6 Other (Specify)  28d. Describe how injury occurred			
Divis	itel or Attencirs after deathrai Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street a City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of City or Town, State of Ci						Rurai Route Number,		
	To the Hospitel or At within 24 hours after o To the Funeral Directompletely filled in by	Aedicai	(Check only 2 Medical Exami	sician: To the best oner: On the basis of and manner state	examination a	e, death occu nd/or investig	ation, in my op	inion, death occ	surred at the time, da	ite and place, and d	ue to the cause(s)	
)	To the within To the comple	Σ	29b. Signature and title of certifier	~ D			29c. License	7447		ed. Date signed (Mg prember 1	9,2006	
			30. Name and address of person who of	hora (	que	C9	tunsv	116 1	Merglan	λ,		
	Sta Registr		31. Date filed (Month, Day, Year)	200	r's Signature	Conti	Ī					

DHMH 17 Rev 1/2001

SLEDZIANCWSKI

06-06862 Jonathan L. Spakes

# Please Type or Print in Black Indelible Ink

Physi	ciar	Decedent's Name (First, Middle,Last)	te of Death	Reg No 2006 293							
redical Exa	mine	Jonathan Lee Spakes		Date of Death Month Day Year eptember 11, 2006 3 Time of Death 1342 hrs							
		4a Facility Name (if not institution, give street and number) I 895 East @ Mile Marker 79	4b. City, Town, or Location of Death  Baltimore	eptember 11, 2006 1342 hrs 4c. County of Death							
Funer		5 Social Security Number 414-55-131 6 Sex 7 Age (In yrs. last births	day) If Under 1 Year If Under 24Hrs. 8.  Months Days Hours Min.	Date of Birth (MM/DD/YYYY) 9 Birthplace (State or Foreign Country) Tennes							
any		Usual Residence of Decedent  10a. State 10b County 10c. City, Town or	Location								
Maryland	, out	I Tennessee White I	Sparta	10d Inside City Limit							
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene 27 is marked other than "matural", or items 23a or 28a-f she marite event, the Medical Psuminer may be never as	Director		10f. Zip Code 38583	10g. Citizen of What Country?							
death wit	Firneral	11. Marital Status 1 X Never Married 2 Married Armed Forces?	Was Decedent of Hispanic Origin? ( Specify If Yes, specify Cuban, Mexican, Puerto Ricar	Vec or No. 144 B							
urs after o	≦	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X X to specify	Specify: White							
336 thin 72 houe than "mat	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	cedent's Usual Occupation (Give kind of work d ring most of working life. DO NOT use retired)	one 16b. Kind of Business/Industry							
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<b>₩</b> = = = = =	1	20a Method of Disposition   20b Place of Disposition   2   2   2   2   2   2   2   2   2	5 Olen Rd Sparta T Disposition (Name of cemetery, or other place)	ennessee 38583 20c Location - City or Town, State							
Baltimo permit. Page Department o Important:		4 Donation 5 Other Specify  21 Signature of Funeral Service Licensee Victor Doda	and Cemetery 9/16/200								
Physician	_	23a. Part I Enter the disease, or complications that caused the death. Do not enfailure. List only one cause on each line		Funeral Home, Inc.							
/Medical		Immediate Cause (Final disease a Smoke Inhalation and Thermal		Between Onset and							
		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.	,unco	Death							
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uted nd ransit		events resulting in death) Last  Due to (or as a consequence of):									
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76 icat ph		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth	Fetal death 3 Ectopic pregnancy	23d Date of delivery							
Aecords, P.O. Box 68: The law requires that the death certificate has been signed by the attending page 2 should be detached for use as t	Physician	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)	Month Day Year							
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Division tal or Attendir rs after death al Director: A	icatio	1 Natural 5 Pending Sep 11, 2006 1323 hrs 2 ✓ Accident Investigation	1 ✓ Yes 2 No Passe	nger in motor vehicle fire after collison							
Divis spital or At tours after d teral Direct filled in by	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. 4 Homicide (Specify) Interstate/Express 28f. Location (Street and Number or Rural Route Number, Control of Town, State) 1895 Fast © Mile Marker 70, Politimeers 1895									
Division of Vital To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certifi completely filled in by the funeral director,	ल	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started.  20b. Secret.  1 895 East @ Mile Marker 79, Baltimore, MD  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)									
7. %ii.	ğ :	29b. Signature and title of certifier	29c License number	e, date and place, and due to the cause(s)  29d Date signed (Month, Day Year)							
(10)		Laid Hallan	O.C.M.E.	September 12, 2006							
100	- 1	Name and address of person who completed cause of death (Item 23a)     Carol Allan, MD	n Street, Baltimore, MD 21201								
Sta Registi	ate ³	SEP 1 5 2006 32. Refistrar's Signature	andi)								
		7-5-19									

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2006 2 Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Month 2:25 PM 10 2006 Juanita Frances Smith /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner St Agnes Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖫 F Yrs. Director 276-22-4605 West Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Maryland Baltimore Catonsville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 515 Maryland Avenue USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give WWII Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of th 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Douglas Porter ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Heelth ar Important: If itsm 27 is eny Injury or other trau once. 5911 Fox Glen Court; Elkridge, Maryland 21075 Montella Smith Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State Dulaney Valley 9/14/2006 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Profound **Physician** Sersis day /Medical Due to (or as a consequence of): Examiner two day lostridium Difficile Colitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of) by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autonsy certificete 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 V No or Attending Physician: : After this certification and funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital: 1 ✓Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No I Director: A 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral C completely filled: 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) A. Bushin, MD SEP AS 24385283527 30. Name and oddress of person who completed cause of death (Item 23a) (Type, Print) Caton Ave, Baltimore, MD, 21229 A. Bashir 900 Agnes Hospital 32. Registrar's Signature 31. Date filed (Month, Day, Year) mells) State SEP 1 5 2006 Registrar

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		1 - For State Registrar		State of I	Maryland		rtment of H		and M		jiene,	2006	29396
	7	Decedent's Name (First, Middle, Last)								2. Date of Dea	th	Vana	3. Time of Death
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Funer		5. Social Security No	1 🗆	7. M 2 <b>∑</b> F	Age (In yrs. lasi	t birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Birth (Month, Day	, Year)	Co	thplace (State or Foreign ountry)
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or deg	Finaral	11. Marital Status		<ol><li>Was Decede Armed Force</li></ol>	es?	13. V	Vas Decedent of H Yes, specify Cub	lispanic Orig an, Mexican	gin? (Spec , Puerto F	cify Yes or No- lican, etc.)		<ol> <li>Race - Ame Black, White</li> </ol>	
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and and lem	16	19a. Informant's Na	me/Relationship (Typ	oe, Print)			g Address (Street						
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or of the			☐Cremation 3 ☐Re	emoval from Sta	ite cem	etery, crem	sition (Name of actory or other pla			ate		ation - City or	
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permit. Pages 1 and 2 should by Department of Health and Menta Important; if item 27 is marked any injury or other traumatic.	S C C	P. Signature of Poli	P. Las	saln	)	11	750 Bela	ir Ro	Y E. 1	F. Lass Kingsvi	ahn ille,	Funera , Maryl	l Home, P.A. and 21087
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17		30. Name and addre	ess of person who cor	mpleted cause of	of death (Item 23	Ba) (Type, F	erint) artus St	Bm	nin	enn	21	204	h, Dey, Year)
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State of Maryland / Department of Health and Mental Hygiene, 29397 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** Ruth Rita Sacko 12:11 PM September 11, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Takoma Park Montgomery Washington Adventist Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) August 9, 1918 Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) Funeral Months Days Hours 1 ☐ M 2 🔀 F 206-07-2648 88 Director Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28e-f show the Medical Examiner must be notified at Montgomery Takoma Park 1XYes 2 No Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20912 8103 Sligo Creek Parkway United States death Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. e filed within 72 hours after us Hygiene.
I Hygiene.
other than "natural", or iter 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 X Widowed 4 □ Divorced Completed 15 Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked other any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Theresa M. Boll Leo N. Schoenig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Sacko / Son 8103 Sligo Creek Parkway, Takoma Park, MD 20912 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State September 14, 2006 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland Montgomery Crematorium Inc 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814 21. Signature of Funeral Service License M01433 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. IDo not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Zo year /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed the attending physicien and hed for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical The law requires that the death certificate IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown δ 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed been : 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has autopsy performed? certificate 1 Yes 2 🔯 No the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 2 ER/Outpatient 3□ DOA this After the 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Diractor: in by the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 - Homicide within 24 hours a To the Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of c rtifler 29c. License number 29d. Date signed (Month, Day, Year) 900 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) # 280 intomated Mayland State 5 2006 Registrar

State of Maryland / Department of Health and Mental Hygien 2006 29398 = For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) September 12,2006 **Physician** Neal Saul 7:05 P.™ William /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore City 6416 Fairdel Avenue 8. Date of Birth (Month, Day, Year)
NOV. 19,1940 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number **Funeral** Days Hours 1 ☑ M 2 □ F Yrs. 65 Pennsylvania Director 205-32-0994 Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f ehow any injury or other traumatic event, the Madical Examinat must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Parkville 1 ☐ Yes 2 X No Baltimore Maryland Directo 10f. Zip Code 10g. Citizen of Whal Country? 10e. Street and Number U.S.A. 21234 1416 Dartmouth Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: þ 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manager Tavern 4 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thompson Ruth Saul, Sr. Craig 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) Baltimore, MD 21206 6416 Fairdel Avenue Mr. Clifton M. Saul, Sr. - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slate 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State Holy Redeemer Cemetery 9/16/06 Baltimore, MD 4 □Donation 5 □ Other (Specify) 22 Name and Address of Facility Baltimore, Maryland 21214 21. Signature of Funeral Service Licensee Leonard J. Ruck, Inc. 5305 Harford Rd. 23a. Part1. Enter the disease, or complications that caded the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner anding physicien and use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical this certificate has been signed by the attending in director, page 2 should be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to beath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 - No 1 Yes 2 1 No 1 Tyes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) EX-Wife 1 ☐ Yes 2 No ို 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital t 🗲 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 h To the Fu 29b. Signature License numbe 29d. Date signed (Month Day, Year) and title of certifie 00 31. Date filed (Month) Day. State 1 5 2006

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of Maryla		artment of H rtificate of L			giene Neg. No. 20 (	)6	29399
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Albert D.	Smith				2. Date of Dea Month	Day	Year 06	3. Time of Death 9:30 PM
	Examir		4a. Facility Name (If not institution, give s			4b. City, Town, or BALTI	Location of Death		4c. County		
*	Funeral Director		215-12-5441	7. Age (In yr 8 8	s. last birthday) 3 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day MAR 11	Year) 1923	Cour	place (State or Foreign ntry) RYLAND
	Maryland a-f show	tor	Usual Residence of Decedent	10c. (	City, Town or Lo	cation				1	0d. Inside City Limits 1 XYes 2 □ No
	3a or 28	Il Director	10e. Street and Number  1418 ARGYLE AVENUI	F.		10f. Zip Code	1217		U.S.A		itry?
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Madical Examinar must be mailied as	by Funeral		12. Was Decedent Ever in Armed Forces?  1 XYes 2 No If Yes, Give Year or Dates: 43/		Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp	pecify Yes or No- Pican, etc.)	14. Race Black		
21215-0036	ithin 72 hou ne. han "natura e Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation	16a. Deced (Give life. I	dent's Usual Occupa kind of work done o DO NOT use retired	luring most of work	sing	16b. Kind of Bus	siness/Ind	dustry
	I Hygi other	Be Col	6th grade  17. Father's Name (First, Middle, Last)		DIET	ARY	18. Mother's Nam	e (First, Middle,	VA HOS: Maiden Sumame		<u>.                                    </u>
Maryland	hould be ind Mental I marked or matic eve	70	CLYDE SMITH  19a. Informant's Name/Relationship (Type	ne Print)	19h Mailir	ng Address (Street a	LUCY M		City or Town	State Zin	Cadal
	and 2 salth an n 27 ls		Allan Lee/Son			Linden Av					
altimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e once.		20a. Method of Disposition  1   ☐ Burial 2 ☐ Cremation 3 ☐ Red  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Place of Dispo cometery, cren ARRISON	natory or other place			20c. Location - 0	•	own, State S, MARYLAND
Balt	permit. Departn Imports any inju		21. Signature of Funeral Service License		22 W.	Name and Address ILLIAM C 206 W NOR	s of Facility BROWN COI	MMUNITY			
	Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the de e cause on each line.  On ges  Due to (or as a cons	tive H	er the mode of dying Leavet Fa	P	or respiratory arr	est,		Approximate Interval Between Onset and Death 2 Y Cars
58760,	cate be executed physicien and physicien and sihe burial-transit	dical Examiner	Supurnially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consi							
O. Box 68	death certif e attending ad for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Gc. If yes, outcome of preg 1 □Live birth 2 □ Fe 4 □ Pregnant at time of g □ Unknown	atal death 3	Ectopic pregnancy Other (specify)			23d. Date Mon		ory Day Year
rds, P.	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions con Hyper HNS10n	tributing to death but not r	esulting in the ur	nderlying cause give	n in Part I.	23e. Did to			ne cause of death?
Division of Vital Records,	The ete h page	Completed	Hyperchalestendem	iia				24a. Was a autops perform	sy pr med? de	ere autorior to coreath?	psy findings available mpletion of cause of
Vita	sician: Th certificate rector, pag	o Be (	25. Was case referred to medical examiner?	ospital:		• 3D DOA Othe	26. Place of Deat		-		
ion of	Attending Physician: or death. ector: After this certific by the funeral director.	<b> </b>	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	1 ☐ Inpatient 2  28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injury Work	4 Linuising no	ome 5 Reside 28d. Describe ho			1)
DIVIS	F 5 F C	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Special Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the C	home, farm, stre cify)	eet, factory, office		28f. Location (St City or Town	treet and Numbe n, State)	r or Rura	l Route Number,
	To the Hospitat or within 24 hours efter To the Funeral Dir completely filled in	edical	29a. Certifier (Cineck only one)  1 Certifying Phys 2 Medical Examin	ician: To the best of my k ler: On the basis of exami- and manner stated.	nowledge, death nation and/or inv	restigation, in my op	inion, death occur	and due to the cared at the time, d	ause(s) and man ate and place, a	ner as st nd due to	ated. the cause(s)
	vithin 2	×	29b. Signature and title of certifier  **Massellum**	,		29c. License			9d. Date signed		* * * * * * * * * * * * * * * * * * * *
	14		30. N. e and address of person who con	mpleted cause of death (It	em 23a) (Type,	North	35363 Green	St. Bau	ltrmore,	MD	21201
· ·	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 5 200	32. Tegistrar's Sig	nature	20000			1		

DHMH 17 Rev 1/2001

06-06791 UNK UNK

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 29400 2006 1- For State Certificate of Death Registra Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month CHARLES RICHARD SPENCER **Medical Examiner** 0410 hrs September 9, 2006 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins-Bayview Baltimore N/A 5. Social Security Number 6. Sex 7 Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or **Funeral** Director Months Hours  $_{1}X_{M}$ 22 220-15-5351 MARCH 18. 1984 Country) MD. Usual Residence of Decedent 10c City, Town or Location 10d. Inside City Limits HARFORD **EDGEWOOD** Yes 2 X No 28a-f show MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 21040 USA 844 ANGEL VALLEY CT. 듑 Funera 11. Marital Status . Was Decedent Ever in U.S 13 Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 XNever Married 2 Married Yes 0 3 Widowed Divorced If Yes, Give Year 1 Yes 2 X No specify Specify: BI-RACIAL ş Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 h Department of Health and Mental Hygiene Important: If item 27 is marked other than "n injury or other traumatic event, the Nadical El College (1-4 or 5+) 0 10TH NEVER WORKED NEVER WORKED 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be TRACY SPENCER REGINALD ALLEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TRACY ALLEN/MOTHER 844 ANGEL VALLEY CT., EDGEWOOD, MARYLAND 21040 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State crematory or other place) Burial 2 XCremation 3 Removal from State 9/14/06 METRO CREMATORY BALTIMORE, MARYLAND Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CHARLES S ZEILER & SON 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval List only one cause on each line. /Medical Death Sharp Force Injuries Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last due to (or as a consequence of). and Physician/Medical ysician a burial -UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23c If ves. outcome of pregnancy 23d Date of delivery Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? ⋧ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a Was an 24b Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 1 🗸 Yes 2 No 25. Was case referred to medical 26 Place of Death (Check only one) Be Other₄ Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 ٥ 1 V Yes 28a Date of Injury (Month, Day, Year) Sep 9, 2006 27 Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification: Subject assaulted 0320 hrs Natural Pending Yes 2 V No To the Funeral Director: Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f Location (Street and Number or Rural Route Number, City Suicide Could not be (Specify) Other (specify) 8101 Pulaski Highway, Rosedale, MD 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. September 9, 2006 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registrar DHMH 17 Rev 1/2001

OCME 2006

31. Date filed (Month, Day, Year

5 2006

			1 - For State Registrar	State of Ma		id / Depa		lealth and M	Mental Hyg	_	ible.	20101
	Physic		1. Decedent's Name (First, Middle, Las	" y Satter	fiel				2. Date of Dea Month		Year O6	3. Time of Death
	/Medi Examir Funeral		4a. Facility Name (If not institution, give 6100 Everall Ave.	street and number) , Apt. 20	7	last birthday)	Baltimo	If Under 24 Hrs.		4c. County	of Death	lace (State or Foreign
	Director		214-24-9362	<b>2</b> M 2 □ F	78	Yrs. y, Town or Lo	Months Days	Hours Min.	8. Date of Birtl (Month, Day Aug • 28	, 1928	Mar	yland  Od. Inside City Limits
	h the Mary r 28a-f sho r celline	Irector	MD		Balt	timore	10f. Zip Code			10g. Citizen of	What Coun	1 X Yes 2 ☐ No try?
36	d within 72 hours after death with the Maryland jiene. Then "natural", or Hems 23a or 28a-1 show triban "matural", or Hems 23a or 28a-1 show the Medical Evantinat rough be recitified at	by Funeral Director	6100 Everall Aven  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	ue, Apt. 2  12. Was Decedent I Amed Forces?  1 XYes 2 N If Yes, Give Year or Dates:	Ever in U		21206 Was Decedent of Harden Specify Cub 1 ☐ Yes 2 No	dispanic Origin? (Span, Mexican, Puerto Specify:		U.S.A.  14. Rad Bla	ce - Americ ck, White,	
215-00	within 72 hou ene. than "natura he Medical E	Completed b	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12)	ucation	+)	(Give	DO NOT use retire	during most of work	king	16b. Kind of B		dustry
Maryland 21215-0036	be filed stal Hyg ed othe event,	To Be Cor	3rd grade  17. Father's Name (First, Middle, Last)	Satterfiel	Ld	Bake	er	18. Mother's Nam		Baking Maiden Surman		
	nit. Pages 1 and 2 should artment of Health and Men ortant: If item 27 is marke injury or other traumatic.	-	19a. Informant's Name/Relationship (7)  Mary Satterfield,  20a. Method of Disagnition  1 □ Burial 2 ☐ Cremation 3 □	wife Removal from State		6100 Place of Disponentery, crem	Everall sition (Name of matory or other place	ı	207,	Baltimo 20c. Location	re, M	ID 21206 wn, State
Baltimore,	permit. Page Department of Important: If any injury or once.	ſ	4 ☐ Conation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen		Met	22				ppel Fu	neral	Home, Inc.
	enysician /Medical	\	23a/Part1 Enter the disease or come shock or heart failure. List only of the disease or condition resulting in death)	one cause on each lin	10.			_	or respiratory arr	est,		Approximate Interval Between Onset and Death Mmdate
3760,	Examiner  special and and purial-transit	Ical Examiner	Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a Due to (or as a d.	a conseq	uence of):	Infarchi	ase	F 97 300			10 years
.O. Box 68	death certific e attending pl d for use as t	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Feta	Ideath 3	Ectopic pregnancy	/			te of delive	ry Day Year
<u>α</u>	The law requires that the ate has been signed by the bage 2 should be detached.	by	Part II. Other significant conditions of Chronic obstru					en in Part I.				e cause of death?
ıl Records,		Completed	sleep apnea						24a. Was a autops perfori	med?	prior to con death?	psy findings available apletion of cause of
Division of Vital	Attending Physician: The death. ector: After this certificate by the funeral director, pag	ertification: To Be	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpatie 28a. Date of Injur (Month, Day	y	ER/Outpatien 28b. Time of Injury	28c. Injur Wor	y at	h (Check only on ome 5 KReside 28d. Describe ho	ence 6 □Oth		)
Divis	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	O	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc	. (Specify	y) 			28f. Location (Si City or Town	n, State)		
	To the Host within 24 ho To the Fund completely f	Medical	29a. Certifier (Check only one)  1 ☐ Certifying Phyone 2 ☐ Medical Examone  29b. Signature and title of certifier	rsician: To the best of iner: On the basis of and manner sta	examina	wiedge, death	restigation, in my o	pinion, death occur	red at the time, d	ause(s) and ma ate and place, a	and due to	the cause(s)
	1 3 - 8		30. Name and address of person who o	ompleted cause of de	ath (Item	23a) (Tune	D003	5363		9/12	1060	
	C.	t à	Sandra Marsha 31. Date filed (Month, Day, Year)	MD BV	AMC	101	Vorth Gre	ure St.	Baltimor	e, MI	2120	01
	Sta Registr		SEP 1 5 2006	Al de la company	K	Coes	2					

06-06820 Please Type or Print in Black Indelible Ink Anthony Taylor, Jr. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra I. Decedent's Name (First Middle Last) 2. Date of Death Physician/ Month Day Year September 10, 2006 0215 hrs **Medical Examiner** 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore 2100 Block of Guilford Avenue If Under 1 Year If Under 24Hrs 8. Date of Birth(MM/DD/YYYY) 9 Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Director Country) 1 X M ce of Deceden Ob. County Yes 2 28a-f show Director 10g Citizen of What Country Street and Number Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No Race - American Indian, Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes Pages 1 and 2 should be filed within 72 hours after or neut of Health and Mental Hygiene aut. If item 27 is marked other than "natural", or aut: If item 27 is marked other than "natural", or are other trannatic event, the Medigal Examiner. If Yes, Give Year 1 Yes 2 No specify Widowed Δ Divorced ð Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Baltimore, MD 21215-0036 Removal from State Cremation ignature of Funeral Service Licenses Enter the disease, or complications that co Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a Shotgun Wound to Chest Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury triat initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical physician the burial -UNPENDED AMENDED Box 68760, IE EEMALE 23c. If ves, outcome of pregnancy 23d Date of deliver 23b Was decedent pregnant in the 3 Ectopic pregnancy Live birth Day Year Fetal death past 12 months? Pregnant at time of death Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. þ Yes 2 V No 3 Probably 4 Unknown is been sign Completed 24a Was an 24b Were autopsy findings available prior to completion of cause of autopsy has performed? death? certificate h ✓ Yes 2 No 1 🗸 Yes To the Hospital or A tending Physician: 25. Was case referred to medical 26 Place of Death (Check only one) Be Other₄ Hospital: 1 Inpatient ER/Outpatient 3 DOA Residence 6 V Other: Scene After this 1 V Yes 27 Manner of Death 28a Date of Injury 28b Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification: Sep 10, 2006 Subject was shot within 24 hours after dean.

To the Funeral Director: A Natural 5 Pending 1 Yes 2 V No Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. Suicide Could not be determined (Specify) Local Street 2100 Block of Guilford Ave., Baltimore, MD 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one)

Registrar DHMH 17 Rev 1/2001

OCME 2006

State

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d Date signed (Month, Day, Year)

September 10, 2006

and manner stated

Deputy Chief Medical Examiner

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifie

Jack Titus MD.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 29403 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Elizabeth September 14, 2006 4:42 pm Thompson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 913 Essex Avenue Baltimore Essex
If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 14, 1924 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number **Funeral** Min. 1 □ M 2 TF Days Director 82 218 14 9795 Maryland Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If Item 27 is marked other than "naturel", or Items 23a or 28a-f ehow 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No by Funeral Director Baltimore Essex Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 913 Essex Avenue 21221 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Michael Fruend Viola Chester ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2 s Department of Health ar important: if item 27 is eny injury or other trau 900. John Elmer Thompson (Son) 506 Walden St. Brooklyn Park, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 9/18/2006 Baltimore, Maryland Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signaure of Funeral Service Licensee 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 23a. Pal 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, I any, leading to inflinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a consequence of). Examiner or Attending Physician: The law requires that the death certificate be executed igned by the attending physicien and be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check only one Certification: To Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Fesidence 6 Other (Specify) 1 ☐ Yes 2 Ø No 2 ER/Outpatient 3 DOA 27. Mann and Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours efter death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) To the 29c. License number 29b. Signature and title of certifier 29d. Dafe signed (Month, Day, Year) m B D06202 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9110 PHILADELAHINA YDEIV ERT 0 B 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 5 2006 DHMH 17 Rev 1/2001

Ub-Ub541 William Trude Physician/ **Medical Examiner Funeral** Director tant: If item 27 is marked other than "natural", or items 23a or 28a-f shov or other traumatic event, the Medical Examiner must be notified at once, 28a-f show 2 should be filed within 72 hours a and Mental Hygiene MD 21215-0036

mportant: If item 27

permit Pages 1 and 2 s Department of Health a

Physician

Examiner

/Medical

Baltimore,

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Rea. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Day 0934 hrs September 1, 2006 William Trude 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death 302 South Calhoun Street Baltimore 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or unk Months Days Hours oreian unk Country) 1 X M 2 31 1935 Mar Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits 1 X Yes 2 No MD Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? unk 302 South Calhoun Street 21223 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Black unk If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 2 White, etc. 1 Never Married unk 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year Yes 2 X No specify: Specify white <u>م</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) unk unk 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) unk unk Be 70 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) O.C.M.E. 111 Penn Street Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) Burial 2 Cremation 3 Removal from State Donation 5 X Other Specify: in state eral Service Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 ona1d ase, or complications art I. Enter the di al caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval lure. List only one cause on each line Between Onset and Death a. Chronic Alcoholism Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Physician/Medical UNPENDED AMENDED 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Month Dav Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26 Place of Death (Check only one) Be examiner? Hospital: 1 Other₄ Nursing Home 5 Inpatient 2 ER/Outpatient 3 DOA Residence 6 V Other: Scene 1 🗸 Yes No Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural 5 Pending 1 Yes 2 No Accident Investigation

attending physician and or use as the burial - transit fo the Funeral Director:

Division of Vital Records, P.O. Box 68760, page 2 should be detached funeral director. the f filled in by

28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Suicide Could not be or Town, State) determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

wasa

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Melissa Brassell, MD

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

September 2, 2006

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

32. Registrar's Signature

ORIGINAL

22462

**Medical** 

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No.2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** ALFRED A VOLKMAN 209 11: COPM 1.0 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) HOWARD COUNTY GENERAL HOWARD HOURITAL 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral**  Birthplace (State or Foreign Country) Months 1⊠M 2□F Director 27, 216-01-9183 88 Feb 1918 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "netural; or items 23e or 28a-f show treumatic event, I'm Medical Ever the armst be notified at 1 Yes 2 No Director Baltimore Maryland Arbutus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1807 Sutton Avenue 21227 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 TYes 2 No If Yes, Give WWII Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Importent: If item 27 is marked other the any injury or other treumatic event. Item 2000. <u>Telecommunication</u> Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Adolph Volkman Augusta Roetganger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alfred G. Volkman 2400 Daphne Lane; Alexandria, VA Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ¹ 4 □ Donation 5 □ Other (Specify) St. Paul Lutheran 9/15/2006 Violetville, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Sign dure Funeral Service Licensee 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure/List only one cause on each line. Approximate Interval Between Onset and Death PNEUMONIA Immediate Cause (Final Physician disease or condition resulting in death) DAS /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician end for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached the th 9□ Unknown 9 Unknown by signed b d be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23a. Did tobacco use contribute to the cause of death? þ 2XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 ☐ Yes To the Hospital or Attending Physicien: certific 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 12 Inpatient 2 ER/Outpatient 3□ DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 1. Natural 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No Director: 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide after within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title di certifier 29c. License number 29d. Date signed (Month, Day, Year) MD Sept 11 2006 D60469 30. Name and address of person who completed cause ath (Item 23a) (Type, Print) 755 CEDAR COLUMBIA 31. Date filod (Month, Day, Year) 32 Registrar's Signature State Registrar SEP 1 5 200

DHMH 17 Rev 1/2001

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. N2 006 29406 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 09 **Physician** M. WIEDERMAN DOROTHY 2:00 PM 2006 /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street end number) 4c. County of Deeth Examiner BALT ( MORE

If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

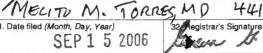
No. 1, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007, 2007 EASTPOINT NURSING HOME 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 1□ M 3€ F 216-36-7302 Yrs. Director 84 September 29,1921 Maryland Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 No Directo MAryland Baltimore Dundalk 10e. Street end Numbe 10f. Zip Code 10g. Citizen of What Country? 7201 Fait Avenue 21224 TISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Dacedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White ģ 3 XWidowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry nd Mantal Hygiana. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Baltimore County Schools <u>Cafeteria Worker</u> 6 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 end 2 should be I Depertmant of Health end Mantal I Important: If Item 27 is marked of John Gray Cary Gray 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dorothy Sanda Daughter 414 Roberts Road, Taylors, SC. 29687 20b. Place of Disposition (Name of cemetery, crematory or other place Moreland Memorial 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 16, 2006 Parkville, Maryland Connelly Funeral Home Of Dundalk, P.A. 21. Signature of Funeral Service Licensee 7110 Sollers Point Road, Dundalk, Md. 23a. Part. Enter the disease, of complications that caused the death. Of not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) of the Examiner Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate ba axecuted burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last ate has been signed by the ettending physician and pega 2 should be detached for usa as the burial-train Due to (or as a consequence of): Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobscco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed Ho Chronic rend insufficience 24a. Was an autopsy performed? after death.

Director: After this certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA fillad in by the funerel 27. Manner of Deeth 28c. Injury et Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physicisn: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie Medicai (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier

Division of Vital Records, P.O. Box 68760 within 24 hours To the Funeral L

> () State Registra

31. Date filed (Month, Day, Year) SEP 1 5 2006



30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

441 S. ELLWood AUG.

20011150

BACTO, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 006 29407 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OSA. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death FORL Age (In yrs. last birthdav) If Under 1 Year 5. Social Security Number if Under 24 Hrs. Birthplace (State or Foreign 1 M 2□ F Months Days Min Hours 5816 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 TNo HARFORI 10f. Zip Code 10g. Citizen of What Country? rne Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race -11. Marital Status 1 ☐ Never Married 2 Married 2 No 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) erglant 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Illiams 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, a 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 Removal from State 21. Signature Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) intarction myocardial Due to (or as a consequence of) Diabetes Two facushtisty ist conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a core eduence of) Hypoer tens Due to (or as a co s ence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2/2/No 1 Tyes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No autopsy 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital:

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

Be

ဥ

**Funeral** 

Director

r then "naturel", or itema 23a or 28a-f ehow the Medical Examinar must be notified at

other then

injury or other traumatic event,

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth any linjury or other traumatic event app.

with the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

Examiner Physician/Medical ð Completed Be ToF Certification:

by the attending physician and stached for use as the burial-transit The law requires that the death certificate be executed bengls need page 2 should be this certificate has director, After death. in by t

Division of Vital Records, P.O. Box 68760, or Attending Physician: within 24 hours after death To the Funeral Director: To the Hospital

cal

State Registrar

Medi 29b. Signature and title of certifie 30. Name Elisabeth

2 No

1 ☐ Yes

27. Manner of Death

1 Accident

3 ☐ Suicide

4 Homicide

(Check only one)

5 Pending investigation

6 ☐ Could not be

MD

20 ER/Outpatient

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b Time of

29c. License number

28c. Injury at Work?

1 Tes 2 No

100 58878

3□ DOA

М

12 Sentifying Physician: To the best of my knowledge, death occurred at the fine, data and place, and due to the daucc(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 9/14/06

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

Parkway Site A Beliamp MO ZK17

and address of person who completed cause of death (Item 23a) (Type, Print)

Tillerus 1321 Riverside 31. Date filed (Month, Day, Year)

1 Inpatient

28a. Date of Injury (Month, Day Year)

5 2006

32. Registrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMNO TIPME OF PRINT (859, 9/19/06 WS)

State of Maryland / Department of Health and Mental Hygiene? 29408 1 - For State Registrar Certificate of Death Month 2. Date of Death 1. Decedent's Name (First, Middle, Last) Alvertis Μ. 2,2006 11:20 M eptember 1 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince George's washingTan was hington 7007 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (in yrs. last birthday) Birthplace (State or Foreign Country) 1 MM 2□ F Days Hours 92 312-09-9460 May 16,1914 Holly Springs, MS Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Prince Georges 1 XYes 2 □ No Fort Washington 10f. Zip Code 10g. Citizen of Whal Country? 10e. Street and Number 2106 Browns Lane 20744-3230 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Yes 2 No 1 Never Married 2 Married Black 1 ☐ Yes 2 🔀 No Specify: 3 ₩idowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Body Shop 8 Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carrie Hoggs Chester Wall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2106 Browns Lane Fort Washington MD 20744-3230 Evelyn Moore/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) With Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cramation 3 MRemoval from State 4 Donation 5 Oher (Specify) Evergreen Memorial Park 09/21/06 Hobart, IN 21. Signature of Fun rai Service Licensee 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc.
1501 Fast Fort Ave Baltimore MD 21230 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Athenoscherotic resulting in death) Due to (or as a consequence of) 303 Sequentially list conditions.

Examiner The law requires that the death certificate be executed physician and s the burial-transit Division of Vital Records, P.O. Box 68760, as the the attending 950 0 detached ģ signed peq peeu page 2 certificate completely filled in by the funeral After t death within 24 hours after death To the Funeral Director: the Hospital or

**Physician** 

/Medical

Examiner

**Funeral** 

Director

iral", or itema 23a or 28a-f ahow Examiner must be nutified at

The Medical

other than

item 27 is marked o

permit. Pages 1 Department of H Importent: If ite any injury or ot 20028.

Enysician

/Medical

Pages 1 and 2

Direct

Completed by Funeral

Be

Examiner

Completed by Physician/Medical

Be 2

Certification:

Medical

should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

cause. Enter Underlying Cause (Disease or injury that initiated events	c.					
resulting in death) Last	Due to (or as a consequence of): _ d					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year			
Part II. Other significant conditions of	contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacco use contribute to the cause of deat  1 Yes 2 No 3 Probably 4 Onk  24a. Was an autopsy findings ava prior to completion of caus	nown		
			performed? death? 1 ☐ Yes 2 ☐ No			
25. Was case referred to medical examiner?		26. Place of De	eath Check only one			
1 as 2 No	Hospital: 1 ☐ Inpatient 2 ZER/Outpatient	3□ DOA Other: 4□ Nursing H	Home 5 ☐ Residence 6 ☐ Other (Specify)			
27. Manneroti Death 1 Natural 5 Pending 2 Accident investigatio		28c, Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred			
3 Suicide 6 Could not b 4 Homicide determined		et, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example 1	nysician: To the best of my knowledge, death niner: On the basis of examination and/or invi and manner stated.	occurred at the time, date and placestigation, in my opinion, death occ	ce, and due to the cause(s) and manner as stated. curred at the time, date and place, and due to the cause(s)			
20h Cinneture and title of portrior		29c License number	29d Date signed (Month Day Year)			

State Registrar

31. Date filed (Month, Day,

Drine, Cheverly transfand Sylvaster 3001 Hospit Yeal) 32. Registrar's Signature

of person who impleted cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

681 s Anderson	We	Please Type or Print in State of Maryland / Department	of Health and Menta		
	F	-For State Amend #11&22 Per FH G8 <b>59-tifild 213 N</b>	A De Ith	Reg. I	10. 2006 2941
Physicia cal Examir		1. Decedent's Name (First, Middle,Last)  James Anderson West		2. Date of Death Month Da September 6	Year 1408 hrs
	ı	4a. Facility Name (if not institution, give street and number) 1700 Edmondson Avenue, Apt. 201	4b. City, Town, or Location of E Baltimore		4c. County of Death
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 2  Months Days Hours	4Hrs. 8. Date of Birth(N	MM/DD/YYYY) 9. Birthplace (State or Foreign
Director	-	215-28-1114   1X M 2 F 74	rs. Normals Days Flours	Apr. 12,	1932 Country) MD
v any	ı	10a. State 10b. County 10c. City, Town or Loc	cation		10d. Inside City Limits
Maryland 28a-f show d at once.	횭	MD Baltimore	10f. Zip Code	I 10g	1 X Yes 2 No Citizen of What Country?
ie r	Director	1700 Edmondson Ave. Apt. 201	21228		USA
ms 23a be noti	uneral		Was Decedent of Hispanic Origin f Yes, specify Cuban, Mexican, P	? ( Specify Yes or No-	14. Race - American Indian, Black, White, etc.
or death	Fun	1 X Yes 2 No	Yes 2 X No specify:	dente Modif, etc.,	
urs afte	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent	dent's Usual Occupation (Give kin		Specify: black bb. Kind of Business/Industry
an "na	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	most of working life. DO NOT us		Social Security
uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	g mo	12 2 Claim 17. Father's Name (First, Middle, Last)	Adjuster 18.Mother's	Name (First, Middle, Mai	Administration
tal Hyg ked of	Bec	James Anthony West	Viola	, , ,	,
	리	19a. Informant's Name/Relationship (Type, Print )	ling Address (Street and Number		
s I and 2 sho of Health and If item 27 is ner traumati			Sturbridge Dr.		MD 21234 0c. Location - City or Town, State
permit. Pages I and 2 shou Department of Health and I Important: If item 27 is r injury or other traumatic		1 X Surial 2 Cremation 3 Removal from State crematory or	other place)	9/15/2006	Owings Mills,Md
permit. Pages I a Department of He Important: If ite injury or other to		4 Donatton 5 Nother Specify: in State Gallison 21. Squature of Funeral Service Licensee Ronald S Wade, Director	2. Name and Address of Facility	lowell Fune	ral Home Baltimore Street 4600 Liberty Heights
Dep Inju		Ronald S. Wade, Director B. 234 Part I. Enter the disease, or complications that caused the death. Do not enter	altimore, MD 21	261 21207	4600 Liberty Heights shock, or heart Ap roximate 1
xaminer	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. Atherosclerotic Cardiovascular E Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):			
executed an and al - transit	ਰ	d. UNPENDED AMENDED			
ate be e	Medi	IF FEMALE: 23c. If yes, outcome of pregnancy	1162		23d. Date of delivery
To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	Physician/Medic	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  1 Live birth 2 Pregnant at time of 4 Pregnant at time of 1 Unknown	Fetal death 3 Ectopic p Other (Specify)	regnancy	Month Day Year
that the danced by the		Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part		cco use contribute to the cause of death?  2 No 3 Probably 4 Unknown
rate or Attending Physician: The law requires that it rate death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Completed by			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
cian: The la certificate h ector, page	Com			1 Yes 2	
sician: s certi irector	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpati	26.Place of Death (Content 3 DOA Other:		esidence 6 🗸 Other: Scene
ding Physi After this funeral di	.: To	27. Manner of Death  28a. Date of Injury  (Month Day Year)  28b. Time		28d. Describe how	
or Attendir after death. Director: A I in by the fu	atio	1 V Natural 5 Pending 2 Accident Investigation	1 Yes 2 1		
al or A s after al Direc	Certification:	3 Suicide 6 Could not be determined (Specify)	street, factory, office building, etc.	28f. Location (Stre or Town, Stat	eet and Number or Rural Route Number, City e)
To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only)  One)  4  Medical Examiner: On the basis of examination and/or investigation.	ocurred at the time, date and placingation, in my opinion, death occu	e, and due to the cause(s	s) and manner as started. d place, and due to the cause(s)
To the within To the comple	Medical	and manner stated.  29b. Signature and title of certifier	29c. License number		9d. Date signed (Month, Day, Year)
		Theodo, M. Kin JR mo.	O.C.M.E.		September 8, 2006
		30. Name and address of person who completed cause of death (Item 23a)	111 Ponn Street Palt	more MD 21201	
	tot-	Theodore M. King, Jr., MD. Assistant Medical Examiner  31. Date filed (Month, Day, Year)  22. Registrar's Signature	111 Penn Street, Balti	more, MD 21201	<del></del>
ت Regis	tate trar	- 000C	MED	- · · ·	

DHMH 17 Rev 1/2001 OCME 2006

06-06866 Adam J Witte

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		tificate of t		Re	g No. 201	16 2941
Physicia Medical Exami	-111/	Decedent's Name (First, Middle, L  ADAM	JONATHAN		WITTE	Date of Death     Month     Septembe		3. Time of Death 1557 hrs
		4a Facility Name (if not institution, of Howard County Hospital		45	. City, Town, or Location		4c. County of Dear	th
Funeral			Sex 7. Age (In yrs. las	st birthday)		er 24Hrs. 8. Date of Birt	h (MM/DD/YYYY) 9. Bi	
Director			X M 2 F 35	Yrs.	Months Days Hours	Min. 08/07/1	.971 Forei	ign ountry) MD
any	ł	Usual Residence of Decedent  10a State 10b County	10c. City, 7	Town or Location	1			10d. Inside City Limits
Aaryland 28a-f show any 1 at once,	ē	FL BROWARI	LIG	HTHOUSE				1 Yes 2 X No
th the Maryland 23a or 28a-f sho <u>notified at once</u> .	Director	10e Street and Number 2100 N.E. 39tl	street APT. 10		10f. Zip Code 33064	10	Og Citizen of What Cou	
th with tems 23 st be 119	Funeral	11. Marital Status  1 Never Married 2 X Marri	12. Was Decedent Ever in U.S ed Armed Forces?		Decedent of Hispanic Ori s, specify Cuban, Mexicar		14 Race - Ame White, etc.	rican Indian, Black,
after dea al", or it	by Fur	3 Widowed 4 Divorce	If Yes, Give Year or Dates:		es 2 X No specify			WHITE
2 hours "natur Exam		15. Decedent's Education (Specify Elementary/Secondary (0-12)	only highest grade completed)  College (1-4 or 5+)		Usual Occupation (Give t of working life DO NOT		16b. Kind of Business	/Industry
5-0036 led within 72 tygiene other than '	Completed		4	WAITER			RESTAUR	ANT
21: be fill htal F ked	Be Co	17. Father's Name (First, Middle, La GLENN	st)	WITT		r's Name (First, Middle, N LINDA	flaiden Surname)	RADITZ
MD 21 rd 2 should the lth and Mer m 27 is mar	٦	19a. Informant's Name/Relationship VANESSA WITTE			Address (Street and Nur W. 8th AVEN			
t is tear		20a. Method of Disposition  1 Burial 2 X Cremation		lace of Dispositi rematory or othe	on (Name of cemetery, r place)	Date	20c. Location - City o	r Town, State
Baltimore, permit Pages I as Department of He Important: If ite		4 Donation 5 Other Spec 21 Signature of Funeral Service Lic	_{fy:} CARF	ROLL CRE	MATION INC. me and Address of Facilit	09/14/2006	HAMPSTEAD	, MD
Balpermi permi Depar Impo		21 Signature of Funeral Service Lic	attle	22. Na		SOL LE RSTOWN ROAD	VINSON & B - PIKESVI	KUS., INC. LLE, MD 2120
Physician		23a. Part I. Enter the disease, or co failure. List only one cause on		Do not enter the				Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Narcotic intoxica  Due to (or as a consequence of)					Death
	-e	Sequentially list conditions, if any, leading to immediate	b.  Due to (or as a consequence of)	):			-	
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequence of)	):				
ecuted and - transit		events resulting in death) Last	d					
al al	Medical	XUNPENDED			,perME,g859,9/	19/06 TT	17	
		IF FEMALE 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn	2 Feta	I death 3 Ectop	ic pregnancy	23d Date of delive Month	ry Day Year
Box 687 e death certifi the attending ed for use as t	/sician	1 Yes 2 No 9 Unkno	<ul><li>4 Pregnant at time of dea</li><li>wn   9 Unknown</li></ul>	ath 5 Othe	er (Specify)			
D.O. Bothat the dended by the	y Phys	Part II. Other significant condition		sulting in the un	derlying cause given in P		bacco use contribute to	
S, P. uires th n signe	ed by					1 Yes		obably 4  Unknown
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the staff redeath and Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact	Completed					autop	sy prior to	completion of cause of
tal Rec		25. Was case referred to medical	1		26.Place of Death	1 Yes :	2 No 1 V	es 2 No
Vita sician this cer	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient	Othor		Residence 6 🗸 Othe	er: Scene
n of ding Pl		27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Inj	1 Van 2	I No.	now injury occurred	
ivisior or Attenc after death Director:	icati	2 Accident Investig	ation 28e Place of Injury - At ho	Find 3:15 me, farm, street	Pin	ate 28f Location (5	Street and Number or R	tural Route Number, City
Div Div nital or ours after	Certification:	Suicide 6 X Could r  4 Homicide determine	ot be	n apartme		Columbia	tate) 10405 Hic.	kory Ridge Rd.
Division of Vital Records, P.O. Box 68: To the Hospital or Attending Physician: The law requires that the death certificate the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical C		ician: To the best of my knowledgner: On the basis of examination ar					
9 5.½ <b>5</b> 8	Me	29b. Signature and title of certifier	and manner stated		29c. License number	r	29d Date signed (M	onth, Day, Year)
		Carder	allan		O.C.M.E.		September 12,	2006
7		30 Name and address of person will Carol Allan, MD Assis			treet, Baltimore, MI	D 21201		
S	tate	31. Date filed (Month, Day, Year)	32. gistrar's Signatu		<i>M</i> .			
Regis	trar	SEP 1 4 2	006   filosope L	7. Appar	w			
DHMH 17 Rev 1/2	2001		100	ORÍGINAL				

			For State Registrar	State of Maryla		artment of F		Mental Hyg	iene •9. No 2006	29411
	Physici	an	Decedent's Name (First, Middle, I Helen	_{ast)} Zakrzewski		-		2. Date of Deal Septem		3. Time of Death 06 1:50A м
	/Medic Examin		4a. Facility Name (If not institution, g			4b. City, Town, or	r Location of Dea		4c. County of Dea	
	Ø. ø		Eastpoint Nur		land birds do h	East]	point If Under 24 Hi	70 0 D 1 1 1 D 1 1	Baltime	
	Funeral Director		214-03-2567		s. last birthday) 91 Yrs.	Months Days	Hours Mi		Year) M.C	thplace (State or Foreign LyLand
	land		Usual Residence of Decedent  10a. State 10b. County	10c. (	City, Town or Lo	ocation				10d. Inside City Limits
	e Man	ctor	Md. Balt	imore	Dunda	1k				1 ☐ Yes 2 No
	h with th	al Dire	10e. Street and Number 7623 Spruce R	.oad		10f. Zip Code 2122	22	1	0g. Citizen of What Co USA	ountry?
<b>'</b> 0	fter deat r items 2	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces?  1		**		(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, Whit	
0036	hours a	þ	3₺ Widowed 4 □ Divorced	Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:			White
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other then "naturel', or Items 23a or 28a-f show enty injury or other traumatic event, I.e. Medical Exemple man De notified at ance.	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired Me Make1	during most of w d)	rorking	16b. Kind of Business	Home
d 21	filed w Hygier other ti	e Col	8th 17. Father's Name (First, Middle, La	st)	110	ale Hakel		ame (First, Middle, I		Trome
Baltimore, Maryland	ould be Mental arked atic ev	To Be	John Stachli					Kuzej		
Mar	nd 2 sh Ith and 27 is m r traum		19a. Informant's Name/Relationship Alan Zakrzews			•			c. City or Town, State, . more, Md	
ore,	of Hea	·	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	20b	. Place of Dispo	osition (Name of matory or other place	1	-	20c. Location - City or	
I I	it. Pag rtment rtant: i njury o		4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lice	city) St		nislaus				e, Maryland
Ba	Depa impo eny ii		21. Signature of Pulled Service Elect	laut					imore, Mo	l Home,PA d. 21222
R			23a. Part1. Enter the diseas , or co shock, or heart failure. List on Immediate Cause (Final	implications that caused the de ty one cause on each line.	eath. Do not en	ter the mode of dyin	ng, such as cardi	ac or respiratory arre	est,	Approximate Interval Between Onset and Death
he.	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a cons	equence of):					
	Examiner	2	Sequentially list conditions,	b. () EMEN	TTA soluence of):					
V	acuted nd transit	Examiner	Sequentially list conditions, Tarry leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events	c						
8760,	ate be executed obysician and the burial-transit	lical Ex	resulting in death) Last	Due to (or as a cons	equence of):					
9	rdificat ng phy s as th	Medi	IF FEMALE:					32.0		
O. Box	that the death certifics ed by the attending pt detached for use as t	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9  Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time o 9 □ Unknown	etal death 3	Ectopic pregnancy Other (specify)	′		23d. Date of de Month	livery Day Year
rds, P.O.	sign sign d be	þ	Part II. Other significant conditions	s contributing to death but not r	esulting in the u	inderlying cause giv	en in Part I.		bacco use contribute to	
Vital Records,		Completed						24a. Was a autops perform	24b. Were a prior to death?	utopsy findings available completion of cause of
Vita	Physician: The this certificate harral director, page	Be	25. Was case referred to medical examiner?	Hospital:		Oth	or /	eath (Check only on		
ot	g Physical dispersal di	n: To	1 Yes 20 No 27. Man er of Death	1 ☐ Inpatient 2  28a. Date of Injury (Month, Day Year)	ER/Outpaties 28b. Time o Injury	IL BUA	4 Latursing	1	ence 6 Other (Spe ow injury occurred	icity)
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<u>X</u>	tal or Al	Certification:	4 Homicide determine		nome, rarm, st crfy)	reet, factory, office		City or Town	treet and Number or R n, State)	urai Houte Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier Check only one) Certifying 2 Medical Ex	Physician: To the best of my kaminer: On the basis of examinant and manner stated.	nowledge, deat ination and/or in	h occurred at the tin vestigation, in my o	me, date and pla pinion, death oc	ce, and due to the ca curred at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To the To the Comp	M	29b. Signature and title of certifier	)		29c. Licens	+ + 2 +	- 2	9d. Date signed (Moni	th, Day, Year)
	3		30. Name and address of person w	o completed cause of death (I	tem 23a) (Type,	Print) Enthet	Place	e Dus	rdulk-	MD 21255
14	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 5	2006 32. Registrar's Sig	nature	Carles D				

hysici	an	Registrar  1. Decedent's Name (First, Middle, Las     MADELTNE C 77				FI		Death		2. Date of Month		Day	06 Year	3. Time of	
/Medic	al	MADELINE C. ZI				45 025	T	Landina		SEPT.	12	2006 4c. County of	f Dooth	7:00	AM
xamir	er	4a. Facility Name (If not institution, give STELLA MARIS H					rown, or COWS(	Location o	or Death			BALT		E	
ineral	4	5. Social Security Number 6. S	ex 7. Ag	e (In yrs. la	ast birthday)	If Under		If Under Hours	24 Hrs. Min.	8. Date of (Month,	Birth			lace (State o	r Forei
ector		219-07-3677 ¹ Usual Residence of Decedent	□M 2□XF	86	Yrs.	Months	Days	Hours	IVIIII.	MARCH	1,	1920		MI MI	).
Now M		10a. State 10b. County		10c. City	, Town or Lo	cation							1	0d. Inside Ci	
rthen "naturel", or Iteme 23a or 28a-f ehow the Medical Examiner must be notified at	Funeral Director	MD. BALTIMO	RE	J.	ARRETT						1.0	0::: (19		1 🗆 Yes	2 X
a or 2	Dir	10e. Street and Number 3910 FEDERAL HILL	תמ			10f. Zip					100	g. Citizen of W	nat Cour	itry :	
TI SE	era	11, Marital Status	12. Was Decedent	Ever in U.S	S. 13. V	Vas Deced	2108 dent of Hi		igin? (Spe	ecify Yes or Rican, etc.)	No-			an Indian,	
層		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give X	No		fYes, spec 1 ☐ Yes :		n, Mexicar Specify:		Hican, etc.)			c, White,		
LE CO	d by	3 X Widowed 4 □ Divorced	Year or Dates:								1 4		WHI		
nat edica	lete	15. Decedent's Ed (Specify only highest gra	de completed)		16a. Deced (Give life. L	lent's Usua kind of wol DO NOT us	al Occupa rk done d se retired	ation Ju <i>ring</i> mos ()	it of worki	ng	16	Sb. Kind of Bus	siness/In	dustry	
other then	Completed	Elementary/Secondary (0-12) 12TH	College (1-4or 5	i+)	HOMEM							OWN HO	ME		
od othe	Bec	17. Father's Name (First, Middle, Last)						18. Mothe	er's Name	(First, Mid	dle, Ma	aiden Sumame	e)		
	To	CHARLES TAYLOR							E ZOI						
item 27 le marke other treumatic		19a. Informant's Name/Relationship ( DANIEL ZIEGFELD/				-						City or Town, S L, MARY			,
item 2 other		20a. Method of Disposition	5011	20b. PI							_	oc. Location - (			
		1 ABurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		Sacif	ace of Dispo emeter crem ed Hear LAWN	CEME		Cemete	<b>ry</b> 9/14	1/06	В	ALTIMO	RE.	MARYT.A	ND
Important: If eny Injury o once.		21. Signature of Funeral Service Licer		,	22	. Name an	d Addres	s of Facili	ity CF	IARLES	S.	ZEILE	R & :	SON, I	NC
eny l		A Hose			6	224 E	ASTE	ERN A	VE.,	BALTI	MOR	E, MAR	YLAN	D 2122	4
•		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each li	the death	. Do not ent	er the mod	le of dyin	g, such as	cardiac o	or respirator	y arres	t,		Approximate Interval Bet Onset and I	ween
sician edical		Immediate Cause (Final disease or condition resulting in death)	a Vas	cul	ar	1).	em	ent	DI					year	
miner			Due to (or as	a consequ	ience of):									J	
	Jer	Sequentially list conditions, if any, leading to immediate	b. — Due to (cr as	a consequ	ianca of).			-							
physician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C												
cian a	EX	resulting in death) Last	Due to (or as	a consequ	ience of):										
physics stress	edical		_ d								_		. 1		
nding ph	Z/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			75-t-nin						23d. Date	of delive	ery	
by the attertached for	Physician/Med	in the past 12 months? 1 ☐ Yes 2.本No 9 ☐ Unknown	1 □ Live birth 4 □ Pregnant at 9 □ Unknown			Ectopic pr Other (sp					_	Mon	nth	Day *	Year
8 8		Part II. Other significant conditions of	ontributing to death b	ut not resu	ılting in the u	nderlying c	ause giv	en in Part I	l.	23e. D	id toba	cco use contri	ibute to th	ne cause of c	death'
n sign	d by	Huperten	SION							1	□ Yes	2 🖾 No	3 🗌 Prob	ably 4 🗆	Jnkn
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page 2	E									p 1 □ Ye	utopsy erforme s 2{	ed? d	eath?	2.⊠'No	ause
certific rector,	Be (	25. Was case referred to medical examiner?					Lou		e of Death	Check on	ly one	0.			
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lter ner	tlon	1 √ Natural 5 Pending 2 Accident investigatio	28a. Date of Inju (Month, Da	y Year)	Injury	M	28c. Injur Worl 1 □	k? Yes 2□		zod. Descri	De HOW	rinjury occurre	94		
ol Director: Al	Certification;	3 Suicide 6 Could not b 4 Homicide determined	e 200 Place of Ini	ury - At ho c. (Specify	me, farm, str	eet, factor	y, office			28f. Locatio City or		et and Numbe State)	er or Rura	al Route Num	ber,
To the Funerel D completely filled in	Medical C		nysician: To the best niner: On the basis o and manner st	f examinat											;)
To th compl	Me	29b. Signature and title of cerifier	1.0	X		290	c. Licens	e number		_	290	d. Date signed	(Month,	Day, Year)	-
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-			·	17.	00+) (T	Drint)						1			
1		30. Name and address of person who	completed cause of o	leath Item	(1ype,	Phinty						D 2109.			

DHMH 17 Rev 1/2001

6:53 A.M.

MADELINE ZIEGFELD SEPTEMB R 12, 2006

State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** William Douglas Angstadt 12, 2006 September 6:50 A /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Oeath Examiner Julia Manor Health Care Center Washington Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeaf 921 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1X M 2 ☐ F Director 096-12-0077 84 October 21, Washington Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "naturel", or Items 23s or 28s-1 sho: traumatic event, if a hedical Exercit or round to rutility at 1 ☐ Yes 2 No Directo Washington Hagerstown Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21742 20009 Rosebank Way Apt.# 121 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ WWII Specify 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Professional Baseball Player Sports 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be innent of Health and Mental in the month of Health and Mental in the marked o George L. Angstadt Carroline E. Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 is eny injury or other trau Mary Ellen Lewis (Friend) 119 Sunflower Drive Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X☐ Cremation 3 ☐ Removal from State September 4 □ Donation 5 □ Other (Specify) Smithsburg Crematory 2006 Smithsburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Maryland 21783 M01414 AVIS 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ypertension Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Atrial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and the burial-transit Diasete The law requires that the death certificate be executed Due to (o as a consequence of): Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò in the past 12 months? Day Month 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Winknown page 2 should Completed been 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate has 2□ No 1 ☐ Yes 2 No 1 🗌 Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending Injury 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1060396 09/12/06 1126 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UM FARID SHE 0 Hogerst egistrar's Signature 31. Date filed (Month, Day, Year) 32 State SEP 1 5 2006 Registrar

			1 - For State Registrar		Maryland / Dep <i>Ce</i>	artment ertificate			nd M	, ,		2006	291	+
(je-	Physic /Medi		Decedent's Name (First, Middle CHARLOTTE ELIZ	ZABETH AUSI						2. Date of Death Month SEPTEMBE		Year 2006	3. Time of De 8:44P	eath M
	Exami	ner	4a. Facility Name (If not institution FREDERICK MEMO	RIAL HOSPI	TAL	4b. City, T FRED	ERIC	K			FREI	DERICK		
	Funeral Director		5. Social Security Number 216-22-8367  Usual Residence of Decedent	6. Sex 1 □ M 2 1 F	7. Age (In yrs. last birthday)	Months		Hours	Min.	8. Date of Birth (Month, Day, ) 6/3/192	(e <i>ar</i> )	9. Birthp Cour MI	place (State or Fintry)	oreign
	be filed within 72 hours after death with the Maryland ital Hygiene.  d other then "naturel", or items 23a or 28a-f ehow event, ita Medical Examinat must be rotified at	Funeral Director	10a. State 10b. County MD Freder 10e. Street and Number 4230 Araby Cht 11. Marital Status	rch Road  12. Was Deced	10c. City, Town or L Freder  lent Ever in U.S. 13.	10f. Zip C	04	panic Origi Mexican,	n? (Spec	10g cify Yes or No- lican, etc.)	USA 14. F	of What Cour	an Indian,	
1215-0036	within 72 hours aft ene. then "naturel", or the Medical Exami	Completed by F	1 Never Married 2 Marr 3 Widowed 4 Divorced  15. Decedent (Specify only highes Elementary/Secondary (0-12)	If Yes, Give Year or Dat	16a. Dece (Give life.	1 Yes 2	Occupation done dura retired)	Specify: on ring most o	of workin	g 16	Spe ib. Kind o	ecify: Whit f Business/Ind	е	
Maryland 2	should be nd Mental marked c	To Be Co	12 17. Father's Name (First, Middle, Thomas F. Summe	rs		omemak	18	Fran	ces	(First, Middle, Ma	iden Sum		Code)	
a)	nit. Pages 1 and 2 artment of Health a ortant: if Item 27 le injury or other tra		Michael S. Aush  20a. Method of Disposition  1 X Burial 2 Cremation  4 Donation 5 Other (S)	3 □Removal from St	Son 4231 20b. Place of Dispo	STAD osition (Name matory or oth	y Chu e of er place)	irch	Soed Da	Frederi	.ck, c. Locatio	MD 217 on - City or To	04 wn, State	
Balt	permit. Departr Import		21. Signature of Funeral Service	Duan	) M00176 1	2. Name and 06 Eas	Address t	ol Facility urch	Keer	ney & Ba	sford erick	P.A.	F.H.	
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cords, r	requires that the een signed by th hould be detache	Ď	Part II. Other significant condition	ns contributing to deal	th but not resulting in the u	nderlying cau	ise given i	in Part I.		23e. Did tobac			e cause of death	
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VISION OF V	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certified completely filled in by the funeral director, I	ation: To Be	examiner?  1 Yes 2 Ye No  27. Manner of Death 1 Matural 5 Pending 2 Accident investig	ation			Other: : Injury at Work?	4 🗌 Nursi	ng Home	Check only one    5 Residence    d. Describe how				
	oral or Attours after de rel Director lled in by ti	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 288. Place of building	Injury - At home, farm, str , etc. <i>(Specify)</i>	·				f. Location (Stree City or Town, S	itate)			
	the Hosp thin 24 hou the Fune impletely fi	Medical	29a. Certifier (Check only one)  12 Certifying 2 Medical E	Physician: To the be xaminer: On the basi	est of my knowledge, death s of examination and/or in r stated.	vestigation, in	the time, my opinionic license nu	on, death	olace, an	at the time, date	and place	e, and due to	the cause(s)	
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	/Medic		Erika Eli			nderson			August		2006	1230 P M
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	anyla ehov	٦ ا				City, Town or Lo						1 ☐ Yes 2 ☑ No
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9	or its	Fu	1 Never Married 2 Marri		2 X No		f Yes, specify Cuba 1 ☐ Yes 21☑ No	Specify:	ruento Hican, etc.)		Black, White,	
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Maryland 21215-0036	al Hyg othe	Bec	17. Father's Name (First, Middle, L	ast)		-		18. Mother's	Name (First, Middle	, Maiden Sun	name)	
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e)	1 end Health em 27		Joseph H. Ande	erson/Son			ring Way sition (Name of	Street	, Conowing		ryland on - City or To	
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Baltimore,	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23a or 28a-1 show any injury or other traumatic event, the Madical Examination at the notified at once.		21. Signative of Funeral Service L		Cr	iurch Ce	emetery	; 5,	, 2006		sylvani	.a
ä	Ded on a special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of the special of t		1 Daniel	8.4	who	10	ocks home 33 W. Sto	ckton	unerals, I Street, E	lkton,	Mary1a	and 21921
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that	caused the de	ath. Do not ent	er the mode of dyin	ng, such as car	rdiac or respiratory a			Approximate Interval Between
а	Physician		Immediate Cause (Final disease or condition	· EN	n STA	56 K	ENDE I	15EAS	٤			Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a conse		M				Fi	19110
٠		70	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a conse	TES /	1841745					( Sept.)
	ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		,	, , , , , , , , , , , , , , , , , , , ,						
o	exec en and rial-tra	Еха	resulting in death) Last	Due to	(or as a conse	equence of):						
8760,	ficate be executed physicien and sthe burial-transit	dlcal		d								
9	ertifica ling pl e as t	0	IF FEMALE:	20 11								
Box	attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	1 🗆 Live	itcome of preg birth 2 Pe nant at time of	tal death 3	Ectopic pregn <i>a</i> ncy Other (specify)	,		23d.	Date of delive Month	ery Day Year
o.	Attending Physician: The law requires that the death certif readsh. •ctor: Atler this certificete has been signed by the attending by the funeral director, page 2 should be deteched for use as	Physiclan/M	1  Yes 2 No 9  Unknown	9☐ Unkr		death 3L	Other (specify)					
Δ.	s that ned b	by Pt	Part II. Other significant condition	ns contributing to d	leath but not re	-		en in Part I.	23e. Did t	obacco use c	contribute to th	ne cause of death?
ğ	w require been sig should b	ed b	STAGE IN CO	NGESTIVE	E HEA	RT /	gunpe		11	Yes 2□No	o 3 🗆 Prob	ably 4 Unknown
ဝ၁	law re as bee	Completed	(CLASS) CO						24a. Was		b. Were auto	psy findings available mpletion of cause of
Œ	ysician: The laviscontificate has director, page 2	E O							perfo	rmed?	death?	
ita	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hearing			I au		Death (Check only of	one)		
5	Physic this of	- To	1 ☐ Yes 2 No  27. Manner of Death	Hospital: 1 🗆		ER/Outpatien		4   Nursir	ng Home 5 💢 Resi			y)
O	ding Phy h. After thi funeral o	tlon	1 Natural 5 ☐ Pending 2 ☐ Accident investig	(Moi	oth, Pay Year)	Injury	Wor	k? ///// Yes 2 □ No	1	A milary oc	cuiled	
Division of Vital Records,	Atten r deal	Ifica	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Plac	e of Injury - At	home, farm, str	eet, factory, office		28f. Location (	Street and Nu	umber or Rura	al Route Number,
á	s after	Certification:	4  Homicide determine	build	ling, etc. (Spe	N/A			City or To	wn, State)	1/4	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical (	29a. Certifier 1 Certifyin (Check only 2 Medical I	Physician: To the	e best of my ki	nowledge, death	occurred at the tin	ne, date and p	place, and due to the occurred at the time,	cause(s) and date and place	manner as st	tated.
	To the h within 2. To the h complete	Med	one) 29b. Signature and title of certifier	and mar	nner stated.	4	29c. Licens				ned (Month,	
	T Y O		Market Street	1/2001	w MI	7,			95			
			30. Name and address of per on	who completed cau	se f death (It	em 23a) (Tvne	<i>                                    </i>	021	10	16/101	TIDUC (	06,2006
		1.5	M . 1 177	OWN, M	D: 3/0	OO WYN	IAN PARK	DRIVE.	BATIM	ORE T	mo 2	1211
	Sta		31. Date filed (Month, Day, Year)		ojstrar's Sig	natura	9-1					
	Regist	ar	• SEP 15	2006	121,45	M. A.	RAY!					

			1 - For State Registrar	State of Maryland		artmen rtificat					Reg. No	006	29416
	Physici /Medic Examin	al	Decedent's Name (First, Middle, Last,     ROSALYN      G.      4a. Facility Name (If not institution, give     LAUREL REGIONAL He	ROWN street and number)	]	BOOKF 4b. City,	Town, or	Location of	1	Month	29 <b>.</b>	2006 County of Death	3: Time of Death 3:00 A
*	Funeral Director		5. Social Security Number 6. Set 184-03-7421  Usual Residence of Decedent	7. Age (In yrs. I		If Under Months		If Under 2 Hours	4 Hrs. Min.	8. Date of Birtl (Month, Day 12/23/1	h y. Year) 913	9. Birti	place (State or Foreign untry) PA
	e-f ehow	ctor	10a. State 10b. County	GOMERY 10c. City	, Town or Lo		SILV	ER SPI	RING				10d. Inside City Limits 1    Yes 2 □ No
	with the	Dire	10e. Street and Number 11612 LOCKWOOD DRIV	VE.		10f. Zip	Code	209	904		10g. Citiz	zen of What Co	untry?
36	be filed within 72 hours after death with the Maryland nat Hygiene.  do other then "natural", or iteme 23a or 28e-f ehow event. Ite Medical Exactinat must be notilled at	by Funeral Director		12. Was Decedent Ever in U. Armed Forces?  1 Yes, 2 XNo If Yes, Give Year or Dates:		Was Deced If Yes, spec				cify Yes or No- Rican, etc.)		14. Race - Ame Black, White Specify:	rican Indian,
21215-0036	within 72 hou ene. then *natura	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		life.	dent's Usua kind of wo DO NOT us	rk done a se retired	luring most	of workin	ng .		of Business/I	·
	should be filed withling Mental Hygiene. marked other then matic event, Its M	Be	17. Father's Name (First, Middle, Last) MORRIS CROWN		1101	- LILIMIN				(First, Middle,			.E.
Maryland	should the market umatic	ဥ	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailii	ng Address	(Street a			JBINSKY	ar. City or	Town, State, Z	Tip Code)
Baltimore, Ma	permit. Pages 1 and 2 should be Department of Health and Menta important: if item 27 is marked ery injury or other traumatic engine.		MARILYN BARGTEIL  20a. Method of Disposition  1 ☐ Surial 2 ☐ Cremation 3 ☑ F  4 ☐ Donation 5 ☐ Other (Specify)	Removal from State		LOCK psition (Nar matory or o	WOOD	DRIV	E, S	SILVER A	SPRI 20c. Lo	NG, MD cation - City or	20904
Balti	permit. I Departm importal eny inju		21. Signatur Funeral S. rvice Licens		ΕĈ	WARD	SAGE ROCKV	s of Facility	ERAL	DIRECT	TION		
4	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the death ne cause on each line.  a. ACUTE STROK  Due to (or as a consequence)	E	ter the mod	de of dying	g, such as o	cardiac or	r respiratory ar	rest,		Approximate Interval Between Onset and Death
8760,	ite be executed with the burial-transit	lical Examiner	Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. HYPERTENSIO Due to (or as a consequence to (or as a consequence)  C. CORONARY AR  Due to (or as a consequence)	N Jenes off: TERY D	ISEAS	SE						
P.O. Box 6	that the death certifice ed by the attending ph detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of do 9 Unknown	death 3	□Ectopic po □ Other (sp					2	23d. Date of deli Month	ivery Day Year
	w requires that been signed by should be deta	à	Part II. Dither significent conditions co	ntributing to death but not resu	ulting in the u	nderlying o	ause give	en in Part I.				_	the cause of death?
al Records,	Physicien: The law re this certificate has ber ral director, page 2 sho	Completed								24a. Was autop perfor 1 🗆 Yes	rmed?	prior to death?	topsy findings available completion of cause of 2 No
Z.	Physicien: r this certifica ral director, r	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 XInpatient 2	ER/Outpatie	nt 3 🗆 DC	Othe Othe			(Check only o		3 □Other (Spec	cifu)
Division of Vital	Attending Phyric death.  octor: After thi by the funeral o		27. Manner of Death 1X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		28c. Injury Work		2	8d. Describe h			204)
Divis	i i i i	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Płace of Injury - At ho building, etc. (Specify	r) 					City or Tow	vn, State,	)	iral Route Number,
	ithe Hospitel thin 24 hours a the Funerel I mpletely filled	edical	29a. Certifier 1 🔼 Certifying Phy (Check only one)	rsician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred vestigation	at the time i, in my op	ne, date and pinion, deat	d place, a h occurre	and due to the a	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	Within To the	W	29b. Signature and title of certifier	the MD		29	D00	64539				e signed (Mont) ${ m ST}$ 29, 2	
			30. Name and address of person who c				Ţ.AŢ	REL .	MD 2	0707			
	St: Regist		31. Date filed (Month, Day, Year)	32 Segistrar's Signa						0.101			

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certificate of Death	Reg No 2006 2011
Physicia Medical Exami		1 Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year
iedicai Exami	ner	JOSHUA REX BLANK  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	September 8, 2006
	•	Washington County Hospital	Hagerstown	Washington
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs	s. last birthday) If Under 1 Year If Under 24Hrs.	
Director		214-25-6259   1XM 2   F   13	7 Yrs. Months Days Hours Min.	AUG. 4, 1989 Foreign Country) MARYLAND
ý		Usual Residence of Decedent		
ow any		,	city, Town or Location	10d Inside City Limits 1 Yes 2 X No
faryland 28a-f show	휭	MARYLAND WASHINGTON  10e. Street and Number	BOONSBORO 10f. Zip Code	10g. Citizen of What Country?
ith the Ma 23a or 28 notified	Director	7362 MOUNTAIN LAUREL ROAD	21713	U.S.A.
with t	교	11. Marital Status 12. Was Decedent Ever in		pecify Yes or No- 14. Race - American Indian, Black,
death or iter	Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No		Write, etc.)
hours after "natural", Examiner	≦	Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)	1 Yes 2 X No specify:	Specify. WHITE work done 16b. Kind of Business/Industry
2 hour "natu	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use retir	
036 Ithin 72 ne r than fedical	ם	12	CO-OWNER	CLEANING COMPANY
215-0036 be filed within 7 ntal Hygiene rked other than ent, the Medica	ပ	17 Father's Name (First, Middle, Last)		(First, Middle, Maiden Surname)
21215-0036 uld be filed within 72 Mental Hygiene marked other than '	Be C	REX KEVIN BLANK  19a Informant's Name/Relationship (Type, Print )		DIANE HAWKINS  Rural Route Number: City or Town, State, Zip Code)
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene ten 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Evaniner must be notified at once	ျ	MARILYN D. BLANK/MOTHER	7362 MOUNTAIN LAUREL	, , , , , , , , , , , , , , , , , , , ,
e, N   and 2   Health   item 2		20a. Method of Disposition 20	bb. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State
Baltimore, MD 2 permit Pages I and 2 should Department of Health and N Important: If item 27 is minjury or other traumatic		1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: B		3/2006 BOONSBORO, MARYLAND
altir mit f portar		21. Signature of Funeral Servic / Icensee	22. Name and Address of Facility	7606 Old National Pike
W F G E E			Dean BAST FUNERAL HOME	Boonsboro, Maryland 21713
Physician /Medical		23a. Part Litter the disease, Complications that caused the defailure. List only one cause on each line.		Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)  Diffluoroethan  Due to (or as a consequence	nie intoxication	Death
		Sequentially list conditions, b.		
	iner	if any, leading to immediate Due to (or as a consequenc cause. Enter Underlying Cause	e of):	
1	Examiner	(Disease or injury trial mitiated events resulting in death) Last Due to (or as a consequence	e of).	
executed an and al - transi		d		
2)	n/Medical		23a,27,28a-f,perME,g860,10/2/06	
8760, tificate he ng physici as the buri	n/M	IF FEMALE: 23b. Was decedent pregnant in the 1 Live birth	regnancy  Petal death 3 Ectopic pregna	23d Date of delivery Incy Month Day Year
x 68 th cert ttendir r use a	icia	past 12 months?  4 Pregnant at time of	2	
<b>Records, P.O. Box 6</b> : The law requires that the death cert cate has been signed by the attendir page 2 should be detached for use a	Physicia	1 Yes 2 No 9 Unknown 9 Unknown	at any department of the condentation across successive Dort (	23e Did tobacco use contribute to the cause of death?
P.O.	ğ	Part II. Other significant conditions contributing to death but no	stresulting in the underlying cause given in Fact.	1 Yes 2 No 3 Probably 4 V Unknown
ds, l equires een sig	Completed			24a. Was an 24b Were autopsy findings available
COF	nple			autopsy prior to completion of cause of death?
tal Reco cian: The law certificate has		25. Was case referred to medical	26 Place of Death (Check	1 Yes 2 No 1 Yes 2 No
Vital ysician his cert directo	o Be	examiner? Hospital: 1 Innation 2	Other	ng Home 5 Residence 6 Other
Division of Vital Records, tal or Attending Physician: The law requir is after death all Director: After this certificate has been seled in by the funeral director, page 2 should I		1 V Yes 2 No 28a. Date of Injury 2  27 Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Injury at Work?	28d Describe how injury occurred
ion tendin eath tor: A	atior	1 Natural 5 Pending Fnd 9/8/2006	Fnd 10:59 am	unk
IVISION Or Attendative death Director:	Certification:	3 Suicide 6 Y Could not be 28e. Place of Injury - A	At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State) Roonsboro, MD Abuntain Laurel Rd.
Spital spital neral	Cer	20a Cartifier	ner-Scene	
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death To the Finneral Director: After this certifi completely filled in by the funeral director.	ical	Check only   Certifying Physician; To the best of my know	vledge, death occurred at the time, date and place, and on and/or investigation, in my opinion, death occurred a	
To 1	Medical	and manner stated.  29b. Signature and title of certifier	29c. License number	29d Date signed (Month, Day, Year)
_	_	701 (1010/1)	H O.C.M.E.	September 10, 2006
		30 Name and address of person who completed cause of death (I	Item 23a)	
			ner 111 Penn Street, Baltimore, MD 21	201
	tate		He Read &	
Regis	ucli	OLI I O LOUD A CONTRACT A	F ATTENDED	

			For State Registrar	5	State o	of Mary	/land /				ealth a	and Me	ental Hy	giene Reg. No.	20	006	294	18
Ė	Physicia	an	1. Decedent's Name (First, Middle CA VIV	e. Last)		•	Bow	15.0/	\				2. Date of De	Day		Year	3. Time of Death	
,	/Medic	al -	4a. Facility Name (If not institution	n, aive str	eet and nu		20 W	200		Town, or	Location o	of Death	August			of Death	2120	
	Examin	er	Shady Grove Ac				tal		,		Rockv:				,		gomery	
Ĭ	Funeral Director		5. Social Security Number 578-42-5172	6. Sex	/ 2□F		n yrs. last b	virthday). Yrs.	ff Unde Months	n 1 Year Days	If Under : Hours	Min.	8. Date of Bir (Month, Da	v. Year)	932	Coun	lace (State or Fore try) sylvania	
		l	Usual Residence of Decedent									F	la I C II	. , , ,		10111	Syrvania	
	trylan show		10a. State 10b. County			10	c. City, To	wn or Lo	cation							1	0d. Inside City Lim 1 ☐ Yes 21☐ I	
	Ba-f s	Director		tgome	ry			Roc	kvi1					10 011				
	e or 2	Ö	10e. Street and Number	C+ moo					10f. Zij	Code	208	53		iug. Citi		Vhat Coun	rry r	
	ne 23	Funeral	4411 Bayne		. Was Dec	edent Eve	r in U.S.	13. V	Vas Dece	dent of Hi			cify Yes or No Rican, etc.)	)-	14. Race	- Americ		
136	be filed within 72 hours after deeth with the Maryland the thygiene a the tribute of other than "natural" or items 23a or 28a-f show do then than "natural" or items 23a or 28a-f show awant, I'm Medical Examiner must be notified at	by Fun	1 ☐ Never Married 2 ☐ Mar 3 ☑ Widowed 4 ☐ Divorced		If Yes G	2 🗆 No	rea		í Yes, spe I □ Yes		n, Mexican Specify:	i, Puerto F	Rican, etc.)			k, White, : Whit		
1215-0036	2 hou	ted	15. Deceder (Specify only highe		tion				lent's Usu		ation Juring most	t of workin	19	16b. Ki	nd of Bu	siness/Inc	dustry	
2	ithin 7	Completed	Elementary/Secondary (0-12)	31 9/200 0		/ (1-4or 5+)		life. L	DO NOT L	se retired	)	. 61 *******	.9		_			
2	filed w Hygier other th		12 17. Father's Name (First, Middle,	[ ast]				Sa	lesm	an	18 Mothe	r's Name	(First, Middle	Maiden			s Supply	
lanc		To Be	Calvin M. Bow		Sr.							la Co		, maioen	Obmain.	0)		
=	d 2 should I th and Men 17 is marke traumatic		19a. Informant's Name/Relations Richard J. Bow						-				Route Numb	-			Code)	
altimore,	permit. Pages 1 and 2 Department of Health important: If itam 27 any injurger other tra		20a. Method of Disposition 1 □ Burial 2 □ Cremation		noval from	State		tery, cren	natory or	other place	1 2	Sept.	ate 2,	20c. Lo	cation -	City or To	wn, State	
Ē	it. Pa		4 Donation 5 Other (5				Gate o			-	-	200					, Maryla	nd
Ba	Depa impo any i		> Cinche	3	C	le							Tuneral , W, S				MD 2090	1
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complica t only one	tions that cause on	caused the each line.	death. De	o not ent	er the mo	de of dying	g, such as	cardiac or	r respiratory a	rrest,			Approximate Interval Between Onset and Death	
1	Physician		fmmediate Cause (Final disease or condition resulting in death)	_ a	Rusp	nat	vry	ta	·lun	٨							Lavel	
	/Medical Examiner		resulting in death)		,	o (or as a co												
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	Cur	(or as a so	onsuguene		_								year,	
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	<b>S</b>	0	PN											1 ears	
oʻ	ate be executed hysicien and the buriai-transii	Exa	resulting in death) Last	Ü	Due to	(or as a co	onsequenc	e of):										
8760,		dlcai		d														-
9	leath certifice ettending pl		IF FEMALE:	230	. If ves. o	utcome of p	regnancy								22d Dat	e of delive		
. Box	etten for u	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No		1 Live	birth 2 [	Fetal dea		Ectopic p Other (s						Mor		Day Year	
о. О	t the c by the	hys	9 Unknown		9□ Unk	nown							1					
	The law requires that the death certific sie hes been signed by the ettending p age 2 should be detached for use as	Completed by P	Part II. Other significant condit	ions contri	, ,	death but n			nderlying	cause give	en in Part I.			tobacco u Pes 2	_		ne cause of death? ably 4 □Unkno	
Ö	s been signature	olete						J					24a. Was		24b. V	Vere auto	psy findings availa	ble
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<u>ita</u>	sician: Th certificete rector, pag	Be C	25. Was case referred to medica examiner?								26. Place	of Death	(Check only					
<u></u>	Z 2 5	၉	1 ☐ Yes 2 🕞 No			Impatient	2 ER/0	_			4 🗆 140		ne 5□Res				1)	
o	D 0 0	tlon:	27. Manner of Death  1. ♣Natural 5 ☐ Pendi 2 ☐ Accident invest	ing tigation	(Mo	e of fnjury onth, Day Ye	ear)	nime of Injury	м	28c. Injury Work 1 🗀 '	γaτ ∢? Yes 2 🗀		l8d. Describe	now injur	y occurr	ea		
Division of Vital Records,	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could	I not be mined	28e. Plac	e of friery ding, etc. (\$	- At home, Specify)	farm, str	eet, factor	y, office		2	28f. Location ( City or To			er or Rura	l Route Number,	
	To tha Hospitel or within 24 hours afte To the Funerai Dirr completely filled in I	Medical C			er: On the	basis of ex	amination :						and due to the					
	o the o the omple	Mec	29b. Signature and title of certific	er	and ma	nner stated			29	c. License	number			29d. Da	te signed	i (Month,	Day, Year)	
	01		> Josph RA	11 m	D				Ĺ	7 7-3	317	7		Ay	st 2	9 7	2006	
	141		30. Name and address of person		pleted car	use of death	h (Item 23a	a) (Type,	Print)	213	GA	-1440	albury	M	> 2	087	7	
	Sta		31. Date filed (Month, Day, Year	r)	32.	Registrar's	Signature	A	male	,							!	
	Regist	ar	SEP 0	1 20	Ub /	PABLAGE	1 10.	PET	-									

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2006 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 28, 2006 Marion Barlen August 11:30 a.m. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖾 F 579-22-9935 88 20, 1918 Delaware Director Jan. Usual Residence of Decedent filed within 72 hours after daath with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 1 ☐ Yes 2 ☐ No Directo Maryland Prince George's the Medical Examiner must be notitie Hyattsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò 238 5923 15th Avenue 20782 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Black, White, etc 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: SpecifyNhite þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Nurse Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pagas 1 and 2 should be fill tmant of Health and Mental H tant: If Item 27 is marked out Be Harvey Wells Lovie Messick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Francis V. Childs/ Son 126 Barbados Drive, Jupiter, Florida 33458 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If It Burial 2 Cremation 3 Removal from State Sept. 27 injury or Arlington National Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2006 Arlington, Virginia 21. Sign if re of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examiner for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) end Box 68760 Physician/Medical Due to (or as a consequence of): signed by the et t be detached to 23b. Did tobacco usa contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 4 Unknown 1 ☐ Yas 2 ☐ No 3 Probably ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed 1 ☐ Yes 1 Yas Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: edicai Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 20 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manuer of Death 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

Hospital or Attending Physician: The law raquires that the death certificeta ba axecuted

Division of Vital within 24 hours after death.

To the Funeral Director: After this cartifics completely filled in by tha funeral diractor, i

To the

State

DHMH 16 Rev 6/95

20

29b. Signature and title of certifie

6 Could not be determined

3 Suicide

29a Certifier

4 I Homicide

31. Date filed (Month, Day, Year)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

completed cause of death (Item 23a) (Type, Print)

30. Name and address of person who

32 Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			For State Registrar	State of Man		artment of F			iene	6 29420
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Yana Serge	eona	Bender			2. Date of Deat Month Aug. 2	h Day Yea 7,2006	3. Time of Death 6:15a M
	Examir		4a. Facility Name (If not institution, give s 1916 Evans Par	kway			r Location of Dea r Sprir	ng	4c. County of De	omery
	Funeral Director		5. Social Security Number 214-41-4225 6. Sex Usual Residence of Decedent	M 20XF 7. Age (7.	n yrs. last birthday) 6 Yrs.	Months Days	Hours Min		Year)	Birthplace (State or Foreign Country) Russia
	h the Marylend ir 28a-f show	irector	10a. State 10b. County MD Montggo	omery	Silver	Spring  10f. Zip Code		1	0g. Citizen of What	10d. Inside City Limits 1 ☐ Yes 2 ☑ No  Country?
36	2 should be filed within 72 hours after death with the Marylend and Mental Hygiene. Is marked other than "natural", or Itsma 23a or 28a-1 show surnatic event, the Midical Extender must be notified at	by Funeral Director	1916 Evans Park  11. Marital Status  12 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ▼No	dispanic Origin? ( an, Mexican, Pue	(Specify Yes or No- into Rican, etc.)	Russia  14. Race - Ai Black, W  Specify:	merican Indian,
Maryland 21215-0036	d within 72 hour jiene. ir than "natural	Completed t	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12)	eation		dent's Usual Occup kind of work done DO NOT use retire	pation during most of w d)	orking	16b. Kind of Busine	ss/Industry
		To Be C	17. Father's Name (First, Middle, Last) Sergei Bender					ame (First, Middle, I Zainova	Maiden Sumame)	
ore, Mar	permit. Pages 1 and 2 should be Deperment of Health and Menta Important: If Item 27 is marked any Injury og-ether treumatic se once.		19a. Informant's Name/Relationship (Ty) Elena Bender/Mo  20a. Method of Disposition 1 © Burial 2 Ocernation 3 OR	ther		16 Evan	s Parkw			g,Md20902
Baltimore,	Depertment Depertment Important: any Injury		4 □Donation 5 □ Other (Specify) 21. Signatural Fundral Service decrease	Z	P ²	241 Col	RINALD	OI FUNER	ver Snri	
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	quires thet n signed b uld be deta	ρ	Part II. Other significant conditions con	tributing to death but n	ot resulting in the u	inderlying cause giv	ven in Part I.			to the cause of death?  Probably 4 □Unknown
al Reco	icisn: The law requir certificate has been si rector, page 2 should I	Completed						24a. Was a autops perform	y prior t	
Division of Vital Records,	ding Phys n. After this funeral dii	atlon: To Be	27. Manner of Death  1 🛣 Natural 5 🗆 Pending 2 🗀 Accident investigation	ospital: 1  Inpatient 28a. Date of Injury (Month, Day Yo	2 ☐ ER/Outpatie 28b. Time o Injury	f 28c. Inju	ner: 4 ☐ Nursing	eath (Check only on Home 5 Reside 28d. Describe ho		Decify)
Divis		Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (	- At home, farm, st Specify)	reet, factory, office		28f. Location (St City or Town	reet and Number or n, State)	Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Director completely filled in	Medical	29a. Certifier 1X Certifying Phys (Check only one) 2 Medical Exemination	ician: To the best of n ler: On the basis of ex and manner stated	amination and/or in	h occurred at the till evestigation, in my o	me, date and place opinion, death occ	ce, and due to the ca curred at the time, da	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
•	Vith To 1	×	29b. Signature and title of certifier	$\sim$		29c. Licens	3363		9d. Date signed (Mo	
			30. Name and address of person who co Shana Jacobs	M.D. 1	11 Mich	igan Av	e.N.W.W	Vashingt	on,D.C.	
*	Sta Registi		31. Date filed (Month, Day, Year) SEP 0 1 20	32 Registrar's	Signature	ale				

			1 - For State Registrar	State c	of Maryland	/ Depa	artment o rtificate	of He	ealth a leath			10y. 140.	2006	29421
	Physici	an	Decedent's Name (First, Middle, Las	t)	Do 1	derin					2. Date of Dea	Day		3. Time of Death
	/Medic		Lorene H.  4a. Fecility Name (If not institution, give	street and nu		dwin	4b. City, To	wn, or L	ocation of	Death	August		County of Dea	1:50
			Citizen's Care 8						ederi					derick
	uneral irector		32 2 3 3 3 3 3	X □M 2QF	7. Age (In yrs. las	t birthday) 7 Yrs.	Months D	ays	If Under 2 Hours		8. Date of Birt (Month, Day uly 18	Year)	10 -0	thplace (State or Foreign ountry) ansas
and	A T		Usual Residence of Decedent  10a. State 10b. County	-	10c. City,	Town or Lo	cation							10d. Inside City Limits
Mary	fled	tor	Maryland Frederic	ck		Fre	derick							1 □Yes 2 X No
th the	or 28e g noti	Director	10e. Street and Number				10f. Zip Co	ode				10g. Citi	izen of What C	ountry?
ath wi	a 23a	rai	6351 Spring Ridge			1	217						USA	
5-UU36 72 hours after death with the Maryland	al', or Items	by Funerai	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Dec Armed Fo 1 Tyes If Yes, Gi Year or D	2 <b>X</b> No		Was Deceden fYes, specify 1 ☐ Yes 25€	Cuban	panic Origi , Mexican, Specify:	in? (Spec Puerto F	cify Yes or No- lican, etc.)		14. Race - Ame Black, Whi Specify: Whi	te, etc.
	of other than "natural; or leans 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest grade Elementary/Secondary (0-12)	de completed) College (		(Give life.	dent's Usual C kind of work o DO NOT use i	done du retired)	ion ring most	of workin	g	16b. Ki	ind of Business	
	other than vent, the Me		17. Father's Name (First, Middle, Last)	2		S	ecreta		18. Mother	's Name	(First, Middle,	Maiden	Govern	ment
d be	marked o	o Be	James Sterling Ho	pkins							y Ellei			
ary shou	S mar	-	19a. Informant's Name/Relationship (7) Robert S. Baldwin,								Route Numbe		r Town, State, MD 20	Zip Code) )740
s tar	ant: If Item 27 I		20a. Method of Disposition  1 3 Burial 2 Cremation 3 1  4 Donation 5 Other (Specify		State cen	netery, crei	sition (Name natory or othe ven Ceme	r place,	1 1	Sept			ocation - City or	
Baltir	Important: If any injured		21. Signature of Funeral Service Licen								Funeral	L Ho	me Inc.	ng, Marylan ng, MD 20901
//\	physician and strength aminer sthe burial-transit	edicai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Dua to	(or as a conseque	nce of):	S- HY	T K PE	COK R-	(E)	NSIE	N		Onset and Death
. Box to death certifi	by the attending phy tached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1 □ Yes 2 □ Mo 9 □ Unknown	1 Live	atcome of pregnand birth 2 ☐ Fetal d nant at time of dea nown	eath 3[	Ectopic pregi Other (speci						23d. Date of de Month	livery Day Year
S, P	signed d be de	by	Part II. Other significant conditions of	ontributing to o	death but not result	ing in the u	nderlying caus	se giver	in Part I.			obacco u		o the cause of death?
2 2	ate has been page 2 shoul	Completed								_			24b. Were a prior to death?	utopsy findings available completion of cause of
Vital sician: T	certificate ector, pag	Bec	25. Was case referred to medical examiner?							of Death	(Check only o	ne)		
of Vita Physician:	this al dir	2	1 ☐ Yes 2 ☐ No			R/Outpatier		Other	4 94001		ne 5 🗌 Resid 8d. Describe h		6 □Other (Spe	ecify)
<b>C</b> 0	After funer	tion	1 Vatural 5 Pending 2 Accident investigation		of Injury 2 oth, Day Year)	Injury	M 200	Injury a Work?	as 2 □ N		od. Describe i	iow iiijui	y occurred	
DIVISION I or Attending	s aner deam. al Director: A ed in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Plac	e of Injury - At hom ling, etc. (Specify)	e, farm, sti	reet, factory, o	ffice		2	8f. Location (S City or Tow			ural Route Number,
Hospital	within 24 hours at To the Funeral D completely filled in	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	iner: On the b	e best of my knowl basis of examination oner stated.									
To the	To thi	Me	29b. Signature and litle of certifier	$\cap$		_	29c. L	icense	number			29d. Dat	te signed (Mon	th. Day, Year)
10			X	P- ~	~ M		I	>5	839	11		9	3-31-	-06
,			30. Name and address of person who	completed cau	use of death (Item 2		Print)	Hon	15R	Ave	e F	181	lossel	, MD
	Sta Regist		31. Date filed (Month, Day, Year)	006 32	Registrar's Signatu		artes				* 1 1 /	nu		21701

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar	Certificate of Death	Reg No. 2006 2010
Physician/ Medical Examine	1. Decedent's Name (First, Middle, Last)		2 Date of Death Month September 11, 2006  2 Date of Death Year September 11, 2006  3 Time of Death 1115 hrs
	4a. Facility Name (if not institution, give street and number) Shady Grove Hospital	4b. City, Town, or Location of Death Rockville	4c. County of Death  Montgomery
Funeral Director	5. Social Security Number 6. Sex 7. Age (I	In yrs. last birthday)  9  Yrs.  If Under 1 Year If Under 24Hrs.  Months Days Hours Min.	8 Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Washington, Country)DC
Au B	Usual Residence of Decedent  10a. State 10b. County 10	Dc. City, Town or Location	10d Inside City Limits
ryland a-f show it once.	Maryland Montgomery  10e. Street and Number	Silver Spring  10f. Zip Code	1 Yes 2 X No
with the Maryland s 23a or 28a-f show a proiffied at once.		20910	USA
ier death v	1 3 Wildowad 4 Hillorcan III Yes, Give Year	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto  1 Yes 2 No specify:	
5-0036 led within 72 hours aft Hygiene other than "natural" the Medical Examine Completed by		during most of working life. DO NOT use retired.	red)
136 E E E E E E E E E E E E E E E E E E E	17. Father's Name (First, Middle, Last)	Student 18 Mother's Name	Elementary School (First, Middle, Maiden Surname)
21215-00 uld be filed with Mental Hygien marked other c event, the M	John David Bartell	Joan	Carol Frank  Cural Route Number, City or Town, State, Zip Code)
MD 27 Ind 2 should the and Me in 27 is ma aumatic ev	Joan Carol Frank/ Mother	9711 Caney Place, Si	lver Spring, MD 20910
nore, ages   ar ant of Hee nt: If iter	20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  4 Donation 5 Other Specify	Metropolitan Crematory 2	2006 Alexandria, Virginia
Baltir permit P Departme Importar	21 Signature of Funeral Service Licensee	500 University Blv	Funeral Home Inc. d, W, Silver Spring, MD 20901
Physician /Medical	23a Pal I. Enter the disease, or complications that aused the failure. List only one cause on each line.	e death. Do not enter the mode of dying, such as cardiac or ythmia due to electrocardial anom	Between Onset and
Fxaminer	or condition resulting in death)  Due to (or as a consequence)		
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Vital Recession: The his certificate director, page	25. Was case referred to medical examiner?	26 Place of Death (Check	only one)  g Home 5 Residence 6 Other:
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To the Hos within 24 h	one) 2 Medical Examiner: On the basis of exami	ination and/or investigation, in my opinion, death occurred a	at the time, date and place, and due to the cause(s)
_	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d Date signed (Month, Day, Year) September 12, 2006
	30. Name and add ess of person who completed cause of dea	ath (Item 23a)	
Stat	Pamela Southall, MD Assistant Medical E		21201
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State of Maryland / Department of Health and Mental Hygien 2006

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**Funeral** 

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "nature!, or Itame 23s or 28a-f ehow any injury or other traumatic event, the Micdical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Division of Vital Records, P.O. Box 68760,

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THORNTON JOHNSON  3439 LIVINGSTUN ROAD  1NDIAN HEAD, MD  20640  229 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the private death of the pr			temovar from State	ST. JOSE	PH CHURCH	CEM. 9/0	05/2006	POMFRET,	MARYLAND	
Approximate in the control of the series of complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest.  Immediate Cause (Final disease or condition resulting in death)  a CONGESTIVE HEART FAILURE  Due to (or as a consequence of):  UNDERLYING CORONARY DISEASE  Due to (or as a consequence of):  UNDERLYING CORONARY DISEASE  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (		New Vi Carone	in your was						1D 20640	
Due to (or as a consequence of):    The properties of the past 12 months?   23d. If yes, outcome of pregnancy   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of d		shock, or heart failure. List only or Immediate Cause (Final disease or condition	conges	e. CIVE HEAR'		ing, such as cardia	ac or respiratory a	rrest,	Interval Between Onset and Death	
23b. Was decedent pregnant at the past 12 months? 1   Yes   2   No   9   Unknown   1   Live plant 12 months? 1   Yes   2   No   9   Unknown   23d. It yes, outcome of pregnancy   1   Live plant at time of death   5   Other (specify)   23d. Date of delivery   Month   Day   Year    1   LUNG   AND   THROAT   CANCER   23e. Did tobacco use contribute to the cause of death?  1   X   Yes   2   No   3   Probably   4   Unknown    24a. Was an autopsy performed to completion of cause of death? 1   Yes   2   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes   Xes	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	a consequence of):	NARY DISE	ASE			20 YRS	
25. Was case referred to medical examiner?  1		23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1☐Live birth 4☐Pregnant at	2 Fetal death		су				
25. Was case referred to medical examiner?    26. Place of Death   Check only one	Phy						00 - Ditt		to the same of the 190	
25. Was case referred to medical examiner?    26. Place of Death   Check only one	ed by		-	ut not resulting in the	e underlying cause g	iven in Paπ I.				
25. Was case referred to medical saminer?  1   Yes 2   Xes   No   Hospital:   1   Inpatient   2   ER/Outpatient   3   DOA   Other:   4   Nursing Home   5   Xesidence   6   Other (Specify)    27. Manner of Death   1   Natural   5   Pending   Investigation   1   Yes   2   No   28a. Date of Injury   At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number, City or Town, State)    28a. Date of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   2b. Time of Injury   28b. Time of Injury   28b. Time of Injury	Complet						autor perfo	prior prior death	to completion of cause of	
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27. Manner of Death 1 Natural 2   Accident 3   Suicide 4   Homicide  28a. Date of Injury (Month, Day Year)  28b. Time of Injury M 28b. Time of Injury M 28b. Time of Injury M 28c. Injury at Work? 1   Yes 2   No  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe now injury occurred  28d. Describe n	0		lospital: 1 🔲 Inpatie	nt 2 ER/Outpa	tient 3 DOA	ther: 4 Nursing	Home 5X Resi	dence 6 Other (S	pecify)	
Tueland G. Fans D02237 MD 8/31/06  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	atlon:	1 X Natural 5 ☐ Pending	28a. Date of Injur (Month, Day				28d. Describe	how injury occurred		
Tueland G. Fans D02237 MD 8/31/06  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	ertific	determined	28e. Ptace of Injubulding, etc	ury - At home, farm, :. (Specify)	street, factory, office	)			Rural Route Number,	
Title Constant G. Fans D02237 MD 8/31/06  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	dicai C	(Check only 2 Medical Exami	ner: On the basis of	examination and/or						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Me	29b. Signature and title of certifier	JOF	ansn	113					
					pe, Print)				0	

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

SEP 0 1 2006

			For State Registrar	State of Maryland		artment of Hertificate of L		nd Mental H	ygiene Reg. No.	2006	294	24
	Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of I	Death	2 2 [°] 0°06	3. Time of Dea 2:45	
	/Medic	al	Song Suk Clayt  4a. Facility Name (If not institution, give st			4b. City, Town, or	Location of			County of Death	2:45	a'''
	Examin	eı	6035 Peccary St.			Waldo:	rf			Charles	3	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la M 2 🕱 F	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2	Min. 6 / Month	aby 12%	9. Birthpla Repub	ce (State or For	reign
	Director		557-27-2402 Usual Residence of Decedent		113.			0/20/	1740	церио	Kore	ea
	nyland show		10a. State 10b. County		, Town or Lo					10	d. Inside City Lir	
	he Ma	Funeral Director	MD Charles	5 W	aldor	-			10- 6	zen of What Count		3110
	an or 3	٥	6035 Peccary St.			10f. Zip Code 2060	U 3		109.01	TT [®] C A	y i	
	death	nera		Was Decedent Ever in U.S     Armed Forces?	5. 13.	Was Decedent of His If Yes, specify Cubar		in? (Specify Yes or	No-	14. Race - America Black, White, e		
92	be filed within 72 hours after death with the Maryland at Hygiene, and Hygiene, or teme 23a or 28a-f ehow event, the Medical Examinar must be notified at		1 Never Married	1 ☐ Yes 2 X No If Yes, Give		1 □ Yes 2√2 No		Toorto (ricari, etc.)			ean	
Ö	hours ture!	ed by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	16a. Dece	dent's Usual Occupa	ition		16b. Ki	nd of Business/Indu		
215	hin 72 9. 9n "ne	Completed	(Specify only highest grade Elementary/Secondary (0-12)		(Give	kind of work done a DO NOT use retired,	luring most ( )	of working			ŕ	
2	i filed wit I Hygiene other the		12	1	поше	maker	10 14-15-4	's Name (First, Midd	//a Adaidaa	Home		
and	d be fi	) Be	17. Father's Name (First, Middle, Last)  Byung Hui Ku					thong Im	ne, Maiden	Sumame)		
ary	2 should be and Mental ie marked o	<b>P</b>	19a. Informant's Name/Relationship (Typ		19b. Mailir	ng Address (Street a			nber, Sity o	r Town, State, Zip (	Code)	
Ž	and 2 selth a n 27 le		Michael Clayton/		1	Peccary	y St.		-			
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Heabils and Menta Important: if Item 27 is marked eny injury or other treumatic ev <u>once</u> .	1	20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State Bri	ace of Dispo emetery crea ISIIE	sition (Name of matory or other place LC no	ľs Cr	em. 9/3		cation - City or Tow Charlott		L,M
Balt	permit. Departr Importa eny Inju		21. Signature of Funeral Service License	Elect MOC	0945	AREHART P.O. Box	世년刊0 567	LS FUNE LaPlata	RAL F	HOME, PA		
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	e cause on each line.							Approximate Interval Betweer Onset and Deatl	n th
£	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)			140	<u></u>	an (e				
	Examiner		ſ	Due to (or as a consequ	ience of):							
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ыпса óf)·	·····						
	ecuted and trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ionea of):							
8760,	ate be executed obysician and the burial-transit	ical E		240 10 (0) 43 4 30 300	JOHOG G. J.							
687	ificate g phys as the	g	0.						- 1			
Box 6	th cert tendin r use	an/M	230. Was decedent pregnant	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnancy				23d. Date of deliver	y Day Year	
P.O. E	he dea the ett	Physician/M	in the past 12 months? 1 □ Yes 2 X No 9 □ Unknown	4☐ Pregnant at time of de 9☐ Unknown	eath 5	Other (specify)				MONTH	Jay 16ai	
	The law requires that the death certificate be executed ate has been signed by the ettending physician and page 2 should be detached for use as the burial-transit	ρ	Part II. Other significant conditions con	tributing to death but not resu	ılting in the u	nderlying cause give	en in Part I.		d tobacco u	use contribute to the	\	
S	w requir s been si should	Completed						24a. W		24b. Were autop	sy findings avail	lable
8	The la	ome						pe	topsy rformed? 2 2 No	death?	pletion of cause 2□ No	3 Of
ital	ertifica ector, p	Be	25. Was case referred to medical examiner?					of Death (Check on				
<del>6</del>	Physician: r this certific rai director,	<u>۲.</u>	1 ☐ Yes 2 ☐ No		ER/Outpatier		4   1401	sing Home 5 Re		6 ☐ Other (Specify) v occurred	)	
O	Attending or death. ector: Alter by the fune	ation	1 Accident 5 Pending Investigation	28a. Date of Injury (Month, Day Year)	Injury	Work	k? Yes 2∐N			,		
Division of Vital Records,	after dea Director	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, sti	reet, factory, office			(Street an Town, State	d Number or Rural	Route Number,	
-	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C		icien: To the best of my kno er: On the basis of examinal and manner stated.								
	To the within 2 To the comple	Me	29b. Signature and title of certifier	<b>A</b> -		29c. License	number	<u> </u>	29d. Dal	te signed (Month, D	Day, Year)	
			> K Mal	l~		n)	85	2		7-1-	06	
			30. Name and address of person who con	P894 1	70		-Ple	- fc 1	1	) 206	346	
\$7	Sta Regist		31. Date filed (Month, Day, Year) SEP 1 4 200	32 Registrar's Signa	J. A	parlis						

State of Maryland / Department of Health and Mental Hygiene

		Certificate of Death	Reg. N2 006 29425				
		Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death				
н	Physiciai /Medica		September 8, 2006 2:05 PM				
	Examine	Ab City Town on I o					
	Funeral Director		8. Date of Birth (Month, Day, Yeer)  Peb. 10, 1929  Maryland				
	pue 🗼	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits				
	8a-f sho	Marria and Correction The court and	1 □ Yes 💥 No				
	ifter death with the Mai r forms 23a or 28a-f si inner invast be notified	10e. Street and Number 3850 Bullfrog Road 21787	10g. Citizen of What Country? United States				
9036	urs e	If Yes, Give 1 Yes 2 No Specify:  Year or Dates:	ecity Yes or No- Rican, etc.)  14. Raca - American Indian, Black, White, etc.  Specify: White				
21215-0036	ed within 72 ho ygiene. her than "natura it, the Modical I	15. Decedent's Education (Specify only highest grede completed)  Elementery/Secondary (0-12)  College (1-4or 5+)  Construction worker					
2	e filed w al Hygier other th		construction e (First, Middle, Maiden Sumame)				
Baltimore, Maryland	should be find Mantal Himmrked out	Coorgo Dobout Colo Cm					
Man	12 sho h and l is me rraume	19a. Informant's Name/Relationship (Type, Print)  Margarette L. Cole / wife  19b. Mailing Address (Street and Number or Rure)  3850 Bullfrog Road					
Ġ,	1 end Health am 27 ather to	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Taneytown, Maryland 21787  Date 20c. Location - City or Town, State				
timo	Pages mant of I tant: If its jury or o	4 Donation 5 Other (Specify)  Smithsburg Crematorium	ep. 11 2006 Smithsburg, MAryland				
Bai	permit. Depertrimportu		iles Funeral Mone				
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	Street Taneytown, Md. 21787 or respiratory arrest, Approximate				
	Physician		Onset and Death				
	/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  a. Lyny (awev	6 mont				
-	إلايت	Due to (or as a consequence of):					
V	rificate be executed ng physician end tes the buriel-trensit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.					
68760,	ate be e hysician the burie	Cause (Disease or injury that initiated events that initiated events that initiated events that initiated events that initiated events the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequ					
	certific nding p						
. Box	death ce e attendii ed for use	Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death?				
P.0	thet tha death cerned by the attendir standed for use		1 Yes 2 No 3 Probably 4 Unknown				
Records,	The law requires thet the death certificate be executed sate has been signed by the attending physician end page 2 should be datached for use as the buriel-trensit		24a. Was en autopsy performed?  24b. Were autopsy findings available prior to completion of cause of death?				
E H	The page	<u> </u>	1				
Zi Zi	certificate ractor, pag	25. Was case referred to medical axaminer?  Hospital: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Other: Othe	(Check only one)				
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ion	death. ctor: After y,the funer	1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1 Manual 1					
Division of Vital	tal or Attanding Pins after death.  al Director: After the in by the funera	3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospital or Attanding Physician: The I within 24 hours after death.  To the Fuheral Director: After this certificate ha completaly filled in by the funeral director, page	29a. Certifier  (Check only one)  1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, a complex of examination end/or investigation, in my opinion, death occurred and manner stated.					
	To the To the comple	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)				
ŀ	1	30. Name end address of person who completed cause of death (Item 23e) (Type, Print)					
	Q	Satishing Shah MD 1030 Fairfield Ko	1, GEHysburg PA 17325				
	State Registrar	31. Date filed (Month, Day, Year) 52. Registrar's Signature SEP 1 5 2006	0 0				

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**ORIGINAL** 

Registrar

State

31. Date filed (Month, Day, Year)

SEP 0

**B**egistrar's Signature

2006

		For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of rtificate of		Re	_{19. No.} 200	6 2942				
Physici	an	1. Decedent's Name (First, Middle, I	ast)				2. Date of Deat Month	Day Ye					
/Medic Examin		Ching Low Chow  4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town,	or Location of Deat		27, 2006					
	CI	SHADY GROVE NURSI			RO	CKVILLE		MONTGON					
Funeral		Social Security Number 6.	Sex 7. Ag	e (In yrs. last birthday	If Under 1 Year   Months   Days		8. Date of Birth (Month, Day,	Year) 9.	Birthplace (State or Ford Country)				
Director		623-22-6301 Usual Residence of Decedent	10AM 201	96 Yrs.			MARCH 14,		CHINA				
r 28a-f ehow Inolified at	tor	10a. State 10b. County  MARYLAND MONTGOM	ERY	10c. City, Town or L	ocation GAITHER	RSBURG			10d. Inside City Lin				
or 28a- a notil	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?				
23a	ral	208 PARK AVENUE, A			2087	<u> </u>		HONG	KONG				
or Items	by Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give	Ever in U.S. 13.	Was Decedent of If Yes, specify Cut  1 ☐ Yes 2 ☒ No	Hispanic Origin? (S ban, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		merican Indian, hite, etc. ASIAN				
natural dical Ex		3 Maridowed 4 ☐ Divorced  15. Decedent's (Specify only highest g	Year or Dates: Education rade completed)	16a. Dece	dent's Usual Occu	pation during most of wor	rkina	16b. Kind of Busine					
iene. r then the Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5	lise.	DO NOT use retire MANAGER	od)		TEXTILE	FACTORY				
atal Hygie ed other i event, th	BeC	17. Father's Name (First, Middle, La:	t)			18. Mother's Nar	ne (First, Middle, N	faiden Sumame)					
nd Menta marked imatic ev	To	ZIYUN CHOW				SOOK	ZHI CHO						
@ <b>2</b> 2		19a. Informant's Name/Relationship					ırai Route Number,	•					
Item 27		WILLIAM S. CHOW - S  20a. Method of Disposition	ON	208 20b. Place of Disp		APT. 310	Date 2	URG, MARYLA					
1 1 1		1 X Burial 2 ☐ Cremation 3		cemetery, cre	matory or other pla	1	. 17.						
Department of Important: If I any Injury or once.		4 Donation 5 Dother (Specify)  GATE OF HEAVEN CEMETERY 9/2/2006 SILVER SPRING, MARYLAND  22. Name and Address of Facility  HINES-RINALDI FUNERAL HOME, INC											
Depa Impo any l		Nonan A	Signature of Funcial Control Control Linguist										
ysician		23a. Part 1. Enter the discusse, or conshock, or heart failing. List on Immediate Cross (Final disease or condition resulting in death)	y one cause on each lir	ne.	ter the mode of dy	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Deat				
Medical aminer				a consequence of):									
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. HYPERTEN  Due to (or as	a consequence of):					A 7-				
and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c										
sicien and burial-transit	cal E	rosulting in osulty cast	Due to (or as	a consequence of);									
> 9		A.	d										
been signed by the attending physicien. should be detached for use as the burial	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnand □ Other (specify) _	у		23d. Date of Month	delivery Day Year				
ned by deta	y Ph	Part II. Other significant conditions	contributing to death be	ut not resulting in the u	inderlying cause gi	ven in Part I.	23e. Did tob	acco use contribute	e to the cause of death				
en sig ould b	led b	DIABETES MELLITU	S			1	1 □ Ye	s 2 □ No 3 □	Probably 4 🖔 Unkn				
certificete has be irector, page 2 sho	mple						24a. Was an autopsy perform	24b. Were prior death	autopsy findings avail to completion of cause				
ficete r, pag							1 Yes 2		es 2□No				
is certific director,	9 Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital:	nt 2 ☐ ER/Outpatie	Ot		th (Check only one						
.99 0	7. To	27. Manner of Death	28a. Date of Injur	y 28b. Time o			ome 5 Resider		pecify)				
ath. or: Att	atlo	1 X Natural 5 ☐ Pending 2 ☐ Accident investigati		(Year) Injury		rk?  Yes 2 □No							
within 24 hours effer death.  To the Funerel Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not 4 Homicide determine		ury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (Str. City or Town,	eet and Number or State)	Rural Route Number,				
24 hour	Medical (	29a. Certifier 1 ☐ Certifying F (Check only one)  1 ☐ Medical Ext	hysician: To the best of miner: On the basis of and manner sta	examination and/or in	h occurred at the ti vestigation, in my	me, date and place opinion, death occu	, and due to the car rred at the time, da	use(s) and manner te and place, and d	as stated. due to the cause(s)				
Mithin To the compl	Me	29b. Signature and title of certifier			29c. Licen	se number	29	d. Date signed (Mo	onth, Day, Year)				
2		Shish _			D 28	8656		AUGUST 29,	2006				
		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type,	Print)								
1		DAVIE DAGGE NO T	5225 SHADY GR	OUT DOAD #2	OO DOGGGGG	TT MADS/T AN	TD 20050						

DHMH 17 Rev 1/2001

		1 - For State Registrar	State of	Marylan	•	artment <i>rtificate</i>				lental Hygi	_	006	29428
Physic /Med		1. Decedent's Name (First, Middle,	Last) Ying	Ch	ow					2. Date of Death	Day 30	2.006	3. Time of Death  6:50AM
Exami		4a. Facility Name (If not institution, HOWARD COUNTY GE				4b. City,		Location o	of Death			onty of Death	
Funeral Director				Age (In yrs.	last birthday) Yrs.	If Under Months		If Under	24 Hrs. Min.	8. Date of Birth (Month, Day, MAY 06,	Year)	9. Birthpl Coun	lace (State or Foreign try) INA
Baltimore, Maryland 21215-0036  permit. Pages I and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel; or items 23a or 28e-1 show any injury or other traumatic event, the Medical Evaniner must be notified at another.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  MARYLAND  10e. Street and Number  10047 FALL RAIN  11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 Divorced  15. Decedent's (Specify only highest Elementary/Secondary (0·12) 6  17. Father's Name (First, Middle, Like KAU CHOW)  19a. Informant's Name/Relationshik KIT BING ROWENA KW.  20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other (Specific Like Choice Like Choice Like Choice Like Choice Like Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choice Choic	DRIVE  12. Was Deced Armed Ford 1   Yes 2   If Yes, Give Year or Date  Education grade completed)  College (1-date)  p (Type, Print)  AN - DAUGHTE  B   Removal from Sacity)	lent Ever in U.ses? 2 \times No les: 4 or 5+)	16a Dece (Give life.) 19b Mailii 10047 11ace of Dispersion of the theory, cree KLAWN ME MENORAH	LAU  10f. Zip  Was Deced If Yes, spec  1 Yes 2  dent's Usua kind of wor DO NOT us  MAID  MAID  The properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the pro	ent of Hingy Cubar  EXI No  I Occupate k done d de retired,  (Street a RAIN ne of her place PARK NS d Addres	specify:  tition uring most  18. 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Box 68760, path certificate be executed Harding physician and to use as the burial-transit for use as the burial-transit	ın/Medicai Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a shock, or head failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):										Date of deliver	Approximate Interval Between Onset and Death  PECS  Ty
I Records, P.O. Box 6 The law requires that the death certific the has been signed by the attending page 2 should be detached for use as	ted by Physician/M	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  Part II. Other significant condition	4□Pregna 9□Unknov		eath 5	□Ectopic pre □ Other (spe	ecify)	n in Part I.		23e. Did tob	acco use c	ontribute to the	Day Year e cause of death? ably 4 □Unknown
	Completed	25. Was case referred to medical									ed? Z No	prior to com death?	osy findings available apletion of cause of 2000 No
ision of ttending Phy death. ctor: After this y the funeral d	Certification; To Be	examiner?  1 Yes Yes No  27. Manner of Death  1 Natural 5 Pending investiga  2 Accident investiga  3 Suicide 6 Could no	28a. Date of (Month)	patient 2 Injury, Day Year)	28b. Time of Injury	M 28	Bc. Injury Work 1 🗆 Y	r: 4 □ Nu at	rsing Hoi	The 5 Resider Resider Resider Resider Resider Resider Resider Resider Resider Resider Resider Resider Resider Resider Resider Resider Resider Resider Resider Resider Resider Resider Resider Resider Resider Resider Resider	nce 6 🗆 0	curred	
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Div  To the Hospitel or A within 24 hours after To the Funeral Dire completely filled in b	Medical	29b. Signature and title of certifier	and manner	sis of examina er stated.	tion and/or in	vestigation,	License	number	th occurr	ed at the time, da	d. Date sig	e, and due to	the cause(s)  Day, Year)
		30. Name and address of person w	no completed cause	of death (Item	7 55 7 55	Print) Ce do	er L	ane	, Ce	lembri	i, n	10 2	2006
St Regist	ate rar	31. Date filed (Month, Day, Year) SEP 0 1	2006	gistrar's Signa	ture do	edi							

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1 Yes 2 Month Day Year)  1 Yes 2 Month Day Year)  27. Mann of Death 1 Month, Day Year)  28a. Date of Injury At home, farm, street, factory, office  28b. Time of Injury at Work?  Month, Day Year)  28c. Injury at Work?  Month, Day Year)  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury				25. Was case referred to me	dical							OC Dinos	of Doeth			1.	☐ Yes 2	2 12 No
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BA 6+1  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Andrea K Baser 1733 Healthway or Bestin MD 21811	)			) ( In	//	no									8/	30/0	)6	
	BF	76-1		30. Name and address of per	son who	completed B	cause of de	eath (Item	23a) (Type, 1	Print) Le	alth 1	wan	Dr	Besk				1
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Cumberland, John R. 229-32-8536 8/4/1931 - 8/29/2006 01755

			ror	partment of Health and Mertificate of Death		ne .No. 2006 29430
	Physici /Medic		Decedent's Name (First, Middle, Last)     Anna Belle Crowe	1	2. Date of Death Month Aug	Day 2006 10:35P M
	Examin Funeral	er	4a. Facility Name (If not institution, give street and number)  Longview Nursing Home  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Months Days Hours Min.	8. Date of Birth (Month, Day, Yo Feb 23	4c. County of Death Carroll  9. Birthplace (State or Foreign Country)
	Director Money		Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or	Location	Feb 23	10d. Inside City Limits
	with the Ma 3a or 28a-f	Funeral Director	MD Baltimore City Ba  10e. Street and Number  155 Grundy Street	1timore 10f. Zip Code 21224		1 ☐ Yes 2 7 No  Citizen of What Country?  U.S.A.
900	within 72 hours after death with the Maryland ene. than "naturel", or items 23a or 28a-f ehow than "naturel", or items 21a or 22 illind at the Marical Examiner mant be mailind at	b		3. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
N	filed within 72 hours Hygiene. thar than "naturel", int, the M. vical Ex.	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  HO	cedent's Usual Occupation ve kind of work done during most of workir n. DO NOT use retired)  memaker	ng	o. Kind of Business/Industry  Own Home
Ĕ	Mental arked o	To Be	17. Father's Name (First, Middle, Last)  Adam Monroe Hodges  19a. Informant's Name/Relationship (Type, Print)  19b. Ma	18. Mother's Name Addie  alliing Address (Street and Number or Rura.	Belle B	rown
σĵ	permit. Pages 1 and 2 shr Department of Health and Importent: If item 27 Is m any injury or other traum once.		M. Anglee Mandish daughter 1  20a. Method of Disposition  Burial 2 Cremation 3 Removal from State  20b. Place of Discemetery, of	920 Cape Road, H	amptste	ad, MD 21074 c. Location - City or Town, State
	death certificate be executed  E and including physician and included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included included inclu	cal Examiner	29a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or influry that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):			Approximate interval Between Onset and Death Q YILS
P.O. Box 68	death certific e attending p id for use as t	Physician/Medl		B⊟Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
	The law requires that the ste has been signed by th page 2 should be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death? 2 □ No 3 🗷 Probably 4 □ Unknown
al Reco		Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?  No 1 Yes 2 No
Division of Vital Records,		Certification; To Be	25. Was case referred to medical examiner?  1  Yes	of 28c. Injury at 2		e 6 □Other (Specify) injury occurred
Divi	pitel or Att urs after d srel Diract		3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		City or Town, S	
	To the Hospitel or Attending Physwithin 24 hours after death.  To the Funerel Director: After this completely filled in by the funeral di	Medical	29a. Certifying Physician: To the best of my knowledge, de (Check only one)  1 Medical Examiner: On the basis of examination and/or and manner stated.  29b. Signature and title of certifier	investigation, in my opinion, death occurre 29c. License number	d at the time, date	and place, and due to the cause(s)  Date signed (Month, Day, Year)
,	WILTA		30. Name and address of person who completed cause of death (Item 23a) (Type	D 51705	minst	8-30-06 2 M) 21157
	Sta Registr	_	31. Date filed (Month, Day, Year) AUG 3 1 2006 AUG 3 1 2006		. 40.4 12 1c	

			1 - For State Registrar	State of Ma	ırylanı		irtment of F <i>tificate of</i>		-	giene Reg. No. 2	0.6	201.31	
	Physici	an	Decedent's Name (First, Middle, Last)	7. 3. 7.3. 7	D				2. Date of De Month	ath Day	Year	3. Time of Death	
à	/Medic Examir	cal	PATRICIA ANN DUVALL  4a. Facility Name (If not institution, give street and number)			LL 	Septe  4b. City, Town, or Location of Death			mber 12,2006 7:31 P M			
	Exami		Frederick Memorial Hospital				Freder			Frede			
	Funeral Director					vrs. last birthday) If Under		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Jan• 2	25, 1944	9. Birthplace (State or Foreign Country) Maryland		
036	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation				11	Od. Inside City Limits	
	a-feh									1 XYes 2 ☐ No			
	death with the Maryland ms 23a or 28a-f ehow rmust be notified at		10e. Street and Number 505 East Church	10f. Zip Code 21701				10g. Citizen of What Country? $U_{\bullet}S_{\bullet}A_{\bullet}$			try?		
	within 72 hours affer death wene. ene. than "natural", or items 23a the Medical Examinationals		11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give A Year or Dates:		11	Vas Decedent of H Yes, specify Cubi	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	14. Race Black Specify:	, White,	etc.	
15-0036			15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done durin		durina most of wor	uring most of working		b. Kind of Business/Industry			
[2]	within than		Elementary/Secondary (0-12) College (1-4or 5		+)		ONOT use retired) mstress			Clothing			
and	d be filed ental Hygic ced other c event, I		17. Father's Name (First, Middle, Last) Harlan William DeGrange							t, Middle, Maiden Sumame) rie Hurst			
Mary	2 should and Men is marks sumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailit				g Address (Street	ddress (Street and Number or Rural Route Number, City or Town, State, Zip Code) st Church Street, Frederick, MD 21701					
more,	1 and Health em 27 ther tr		Leroy Duvall, hu	-	20b. Pf	ace of Dispos	sition (Name of		Date	20c. Location - C			
	permit. Pages Department of Importent: If It eny injury or o		1 Burial XXcremation 3 Re 4 Donation 5 Other (Specify)		Smi		·	Sept. 13,		Smithsbu	irg,		
g C			21. Signature of Foneral Service Libense	/)	00255	22.	Keeney a .06 East	hd Basfo Church S	rd PA Fu t., Fred	meral Ho derick, N	ome ND 2	21701	
	death certificate be executed  e attending physicien and d for use as the burial-transit  and for use as the burial-transit  and for use as the burial-transit		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line.  Immediate Cause (Final Onset and Death										
Å			Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):						1 WEEK				
		ner							2 mants				
N.		Examiner											
58/6U,		on: To Be Completed by Physician/Medical	d.								-		
, r.O. box	death certi e attending d for use a		FEMALE: 3b. Was decedent pregnant in the past 12 months? 1   Yes   2 No   9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   4   Pregnant at time of death   5   Other (specify)   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9								23d. Date of delivery Month Day Year		
	s thet t		Part II. Other significant conditions conti	nbuting to death but	t not resu	lting in the un	derlying cause giv	en in Part I.	*23e. Did to	obacco use contrib	ute to the	e cause of death?	
ecoras,	require een sig nould b		Chronic Obstructive Pulmona				y Disease it			Yes 2 No 3 Probably 4 Unknown			
vilai nec	To the Hospital of Attending Physicien: The law requires thet the within 24 hours after death.  To the Funarel Director. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.								24a. Was autop perfoi 1 ☐ Yes	sy pri rmed? de	ere autop or to com ath? Yes	sy findings available pletion of cause of	
IVISION OF VIEW			25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 XInpatien		ER/Oulpatient	3□ DOA Oth	26. Place of Dea	111 111 1111	70			
			27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 1 Natural 5 Pending								be how injury occurred		
2		catl	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)				M 1 Yes 2 No		204 Leasting (Change)				
2		Medical Certification:				(Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	Ne Hosp 24 hou Ne Funsi Vetely fill		29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	Withir To th comp		29b. Signature and title of certifier 29c. License number							29d. Date signed (Month, Day, Year)			
•	10.		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)										
	12		James S. Gris	SSUM MI	ン	1475	TANEY	AVE #3	104 FR	EPBACK	, M	D. Z1702	
	Sta	te	31. Date filed (Month, Day, Year)	32 Règistrar	r's Signatu	UIO CARTO	- N -						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

Greeke)

			1 - For State Registrar	State of Mar		artment of I rtificate of		Re	9. No 2001	5 29434
	Physici /Medi		1. Decedent's Name (First, Middle Kathleen	Last) Beulal	h1	Downin		2. Date of Death Month Septembe	Day Yea	3. Time of Death  8:05 p M
	Examir		4a. Facility Name (If not institution,				or Location of Death		4c. County of D	
Ser.	-		Homewood at 5. Social Security Number		rt In yrs. last birthday)	Willi II Under 1 Year	Lamsport	8 Date of Birth		ington
	Funeral Director		005 - 01 - 1305		91 Yrs.	Months Days		8. Date of Birth (Month, Day, February		Birthplace (State or Foreign Country) Maine
	yland		10a. State 10b. County	10	Oc. City, Town or Li	ocation				10d. Inside City Limits
	e Mar	ctor	Maryland Wash	ington	Hagers	stown				1 ☐ Yes 2 XNo
	with th	Funeral Director	10e. Street and Number	le to the		10f. Zip Code		10	g. Citizen ol What	-
	leath v	erai	2010 Starlig	12. Was Decedent Eve	er in U.S. 13.	Was Decedent of t		ecify Yes or No-	U.S.A	merican Indian,
920	ours after death with the Marylan el', or Iteme 23a or 28a-1 ehow Examinar must be notified at	þ	1 ☐ Never Married 2 ☐ Marrie 3 🛣 Widowed 4 ☐ Divorced	Armed Forces?		II Yes, specify Cub 1 ☐ Yes 2 No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Black, W	
Maryland 21215-0036	"netur	Be Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	College (1-4or 5+)	16a. Dece (Give life.		during most of work id)	ing	6b. Kind of Busine Medical School	ss/Industry Secretarial
d 2	illed Hygi other	e C	17. Father's Name (First, Middle, L			Teacher		e (First, Middle, M		
/lar	should be filed within and Mental Hygiene. Ie marked other than aumatic event, the Mi	To B	Saul		Mich	aud	Emily	/	Belle	fleur
Mar	s 1 and 2 should f Health and Men Item 27 le merke other traumatic		19a. Informant's Name/Relationsh				and Number or Run			
	1 and Health	1	David A. Dow  20a. Method of Disposition		3U1 / 20b. Place of Dispo cemetery, cre		Ferry Roa		Sburg, Mo	
altimore,	Pages lent of nt: If Ii ry or o		1 ☐ Burial 2 🕅 Cremation 4 ☐ Donation 5 ☐ Other (Sp		cemetery, cre agerstown				•	, Maryland
Balti	permit. Pages 1 and 2 Department of Health a Important: if Item 27 le eny Injury or other trau once.		21. Signature of Funeral Service L	and the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of th			Pass of Facility Coffman ntietam S		-	•
Ē,			23a. Part1. Enter the disease, or o shock, or heart failure. List of	omplications that caused the	e death. Do not en	ter the mode of dyi	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between
-4	Physician		Immediate Cause (Final disease or condition	malian		2	of pan			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a c						
7	1	e	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying	b. Due to (o. as a c	onsequence of).					
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c						
760,	te be executed ysician and te burial-transit	cal Ex	resulting in death) Last	Due to (or as a c	onsequence of):					
89	e Se			d.						T.
.O. Box	The law requires that the death certifica 11e has been signed by the attending phi 2age 2 should be delached for use as th	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes  9 □ Unknown	23c. If yes, outcome of p 1 □Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic pregnance Other (specify)	у		23d. Date of Month	delivery Day Year
Division of Vital Records, P.	w requires that been signed b should be deta	ed by Pi	Part II. Other significant condition Hype, (Yen 9,000	s contributing to death but n		nderlying cause giv	f	23e. Did toba		to the cause of death?  Probably 4 Unknown
600	e law re has bee ye 2 sho	plet	gastroesphag	calierly				24a. Was an autopsy	24b. Were	autopsy findings available o completion of cause of
<u>=</u>		Con	, ,	,				perform	ed? death	
Vita	Physician: this certificanal director, I	Be	25. Was case referred to medical examiner?	Hospital:		- 30 DOA   O#	000	h Check only one		
of		n: To	1 Yes SNo 27. Manner of Death	1 ☐ Inpatient  28a. Date of Injury (Month, Day Ye	2 ER/Outpatier	f 28c. Injur	ry at	me 5 Residen 28d. Describe how	ce 6 Other (Si	pecify)
ion	Attending Firdeath. ector: After by the funer	atio	Natural 5 Pending	tion	ear) Injury	M 1 🗆	rk?  Yes 2 □ No			
Divis	after de Directe d in by t	Certification:	3 Suicide 6 Could no 4 Homicide determin		<ul> <li>At home, farm, str Specify)</li> </ul>	reet, lactory, office		28I. Location (Stre City or Town,	et and Number or State)	Rural Route Number,
	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Chack only one)  Certifying 2 Medical E	Physician: To J e best of m katulner: On the basis of ex and manner stated	amination and/or in	h occurred at the till vestigation, in my o	me, date and place, opinion, death occurr	and due to the car. ed at the time, dat	use(s) and manner e and place, and d	as stated. ue to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	140		29c. Licens	46940		d. Date signed (Mo	
16th	-5		30. Name and address of person w	116. 0110	h (Item 23a) (Type,	Print)	Ave H	lageista.	Dr MI	2006
	Sta Registr	_	31. Date filed (Month, Day, Year) SEP 0 5	2006 32. Registrar's	Signature	este		J		

Amended Items 23a Part I Line a, 23e, & 24a 08/31/2006 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No UU 6 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day **Physician** Year ELIZABETH 130SLE> 08 29 2006 7:45 P /Medical 4a. Facility Name (If not institution, give street and number)
Lookabout Manor 4c. County of Death Examiner Westminster <u>Carroll</u> 7. Age (In yrs. last birthday) 91 yrs. 5. Social Security Number 215-07-5638 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 💢 F Director Mar 18,1915 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Director MD Baltimore Upperco 10e, Street and Number 10f. Zin Code 10g. Citizen of What Country? 3700 Carrollton Road 21155 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Ž☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural, or ite may injury or other traumatic event, the Medical Examena once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 □XVidowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) Own home 18. Mother's Name (First, Middle, Maiden Sumame) Be Daniel W. Bosley Anna Mathews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elmer B. Bosley 3730 Carrollton Rd., Upperco, MD 21155 and Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosition (Name of Disnosit Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 9/2/06 Sparks, MD Bosley United Meth 21. Signature of Funeral Service Licensee Maryland 23a. Pard. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failule. List only one cause on each line. S. Main St. Hampstead Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) END STAGE DEMENTIA Pnysician 6/2004 /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent prediant in the past 12 months?
1 Yes 2 PNo 23d. Date of delivery 3 Ectopic pregnancy Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown MEMU PAILURE CONJESTIVE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes 2**X** No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, to 25. Was case referred to medical examiner? (DU MICMRY Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Spec 1 Inpatient 2 ER/Outpatient 3 DOA 27. Many r of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; 1 Whatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide of fying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The cause(s) and manner as stated.

The cause(s) and manner stated.

The cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of 8-30-2006 MJL 30. Name and address of pelson who completed of Philip Ruzbarsky 125 4 e of death (Item 23a) (Type Print) Airport Dr. Suite 34 Westminster, MD 21157 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar Them It Spark

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death 30 **Physician** BARBARA ALLEN DUDLEY 80 2006 10:55 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HARFORD HARFORD MEMORIAL HOSPITAL HAVRE DE GRACE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. OCT 10, 1932 7. Age (In yrs. last birthday) 73 Yrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Funeral Months 1 ☐ M 2 🛛 F Director 404-52-8641 KENTUCKY Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits and Mental Hygiene.
Is marked other then "nature!", or items 23e or 28e-f show
reumstic event, the Modical Examiner must be notified at 1 XYes 2 No MARYLAND HARFORD ABERDEEN Directo 10e. Street and Number 10g. Citizen of What Country? 759 CUSTIS STREET 21001 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 FOOD SERVICE MILITARY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JESSIE CURRY ANNIE MAE HALIDAY ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GREGORY MOORE / SON 4716 HELLWIG ROAD, BALTIMORE, MARYLAND 21206 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.A. FERRIS & CO. INC 9/5/06 WEST CHESTER, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility LISA SCOTT FUNERAL HOME, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MD 21078 Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Severe **Physician** metabolic acidosis /Medical Due to (or as a consequence of): Examiner Septic Shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): Examin burial-transit Pneumonia Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy certificete has been signed by the atter rector, page 2 should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Lymphoma 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 1 Yes 2∏ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Cneck only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00063420 August 30,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5. UNION AVE HAVVEDE GRACE MAZIOTS KHARAL, MD 501 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 1 2006 Registrar

1055

			1 - For State Registrar	State of Maryland	•		of Health			giene Reg. No 200 (	5 29437
ı	Physici /Medic		1. Decedent's Name (First, Middle, Last) Gilda S. Evans						2. Date of Dea Month August	Day Year	M
	Examin Funeral Director	er	4a. Facility Name (If not institution, give str  Casey House  5. Social Security Number  5.77-36-4446	7. Age (In yrs. la	ist birthday). 75 Yrs.			er 24 Hrs.	8. Date of Birtl (Month, Day Sept. 2	Montgo h, Year) 9. B	
	ס	tor	Usual Residence of Decedent  10a. State  10b. County  Maryland Montgomery	10c. City,	Town or Lo	cation			верс. 2	1930   wa	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	3a or 28a	Funeral Directo	10e. Street and Number 7420 Westlake Terrac	ce, # 702		10f. Zip	Code 0817			10g. Citizen of What C	•
2-0030	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiene.  Department of Heelih and Mental Hygiene.  Department of Heelih and Mental Hygiene.  Department of Heelih and Mental Hygiene.  Proportion of the traumatic event, the Madical Examiner must be notified at once.	þ	11. Marital Status 12 1 Never Married 2 Married 3 XWidowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Deceded Yes, spec	ent of Hispanic C fly Cuban, Mexic		ecify Yes or No- Rican, etc.)		
0-61717	within 72 ho iene. • then "netur he Madical	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12) 12 Years	ation completed) College (1-4or 5+)	life. L	dent's Usual kind of word DO NOT us nemake	ŕ	ost of worki	ing	16b. Kind of Busines Own Hom	•
yland 4	ould be filed Mental Hyg harked other hatic event,	To Be C	17. Father's Name (First, Middle, Last) Nathaniel Oscar				18. Mot	oroth	y Panit	Maiden Sumame) Z	
e, Mar	1 and 2 sh Heelth and Im 27 ie m ther treum		19a. Informant's Name/Relationship (Type Nina L. Eisenberg  20a. Method of Disposition	- Daughter		Lange	lrum Lan	e, Ch		r, City or Town, State, se, Maryla  20c. Location - City o	ind 20815
saitimore,	artment of I ortant: If its injury or o		1 Burial 2 XCremation 3 XRer 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	moval from State Na	metery, cren tional	natory or ot L Cren	natory	8/31/	2006	Falls Chu	rch, Virginia
מ	Depa impo		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	Hottlemes	2	1170 I	Rockvill	.e Pik	e, Rock	al Chapels	yland 20852
	ires that the death certificate be executed XX isigned by the ettending physician end Web detached for use as the burial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Inclusi  Due to (or as a conseque  Aspirat  Due to (or as a conseque  Due to (or as a conseque	on Boo ence of): ion Pr ence of):	dy Myo	sitis				Onset and Death
	the death certific y the ettending p ched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnan  1 Live birth 2 Fetel of  4 Pregnant at time of decent	death 3	Ectopic pre Other (spe				23d. Date of d Month	elivery Day Year
ras, r	The law requires that the site hes been signed by the cage 2 should be detached.	þ	Part II. Other significant conditions contr	ributing to death but not resul	lting in the ur	nderlying ca	use given in Par	rt I.			to the cause of death?  Probably 4 □Unknown
	n: The law re icete hes bee r, page 2 sho	Completed		2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 -					24a. Was a autop perfor 1 Yes	an 24b. Were a prior to death? 2\overline{\Omega} No 1 \square Ye	
_	Attending Physicien: The law requir r death. ector: After this certificete has been s by the funeral director, page 2 should	Certification: To Be	27. Mapner of Death  1 CNatural 5 Pending 2 Accident investigation		ER/Outpatien 28b. Time of Injury		10.	Nursing Hor		ne 6 <b>X</b> Other ( <i>Sp</i> low injury occurred	_{юслу)} Hospice
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	)				City or Tow		
	the Hosp in 24 hos the Fund iptetely fi	edicai	(Check only 2 Medical Examine one)	or: On the basis of my know or: On the basis of examination and manner stated.	nedge, death on and/or inv	vestigation,	in my opinion, d	eath occurr	ed at the time, o	date and place, and du	ue to the cause(s)
	[D	¥	29b. Signature and title of certifier  Grutis M. 31.			ŀ	License numbe			29d. Date signed (Mor Curgust	79, 2006
	Sta	10	30. Name and address of person who com  Cynthia M. Willi  31. Date filed (Month, Day, Year)	iams, M. D. 60	001 Mu	incast	er Mill	Road			
H	Registr		AUG 3 1 200	6 Kages B	Loc	We					

		For State Registrar	State of Ma	ryland /			it of He <i>e of D</i>		Mental H	ygiene Reg. No	2006	29439
Physicia /Medic	_	1. Decedent's Name (First, Middle, Last)	Esther 1	FEROUZ			-		2. Date of D		y 2006 ^{ear}	3. Time of Death
Examine		4a. Facility Name (If not institution, give str Holy Cross Ho						ocation of Death Spring	1	4c.	County of Death Montgom	ery
Funeral Director		5. Social Security Number 6. Sex 1	7. Age M 2 💢 F	(In yrs. last 91	birthday) Yrs.	If Unde Months		If Under 24 Hrs. Hours Min.	Feb.	irth Year	915 Egyp	place (State or Foreign try)
e Maryland 8a-f ehow	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Montgome	ry	10c. City, To	own or Loc		ing					0d. Inside City Limits 1 ☐ Yes 2 🌠 No
h with th	Funeral Directo	10e. Street end Number 1111 University Blv	d., W. #:	308		10f. Zi	2090	)2			izen of What Cour ted Stat	•
S In S	<u>۾</u>	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent E Armed Forces? 1 Yes 27 No If Yes, Give Year or Dates:		i i	Vas Dece Yes, spe	37	panic Origin? (Si Mexican, Puerti Specify:	pecify Yes or No Rican, etc.)	lo-	14. Race - Americ Black, White, Whi Specify:	etc.
d within 72 hc giene. In then "netur	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)			(Give life. [	ent's Usu kind of wo DO NOT L		on ring most of wor	kıng		ind of Business/In wn Home	dustry
uld be file Aental Hy rked oth tic avant,	To Be	17. Father's Name (First, Middle, Last) Sabet Matziach					1	8. Mother's Nam Fortune		le, Maiden	Sumame)	
and 2 should eath and Men m 27 is marke		19a. Informant's Name/Relationship (Type Joseph Ferouz, Son	e, Print)			•		d Number or Ru id, Silv			or Town, State, Zip MD 2090	_
Pages 1 and to 1 de la la la la la la la la la la la la la		20a. Method of Disposition  1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State		stery, cren	natory or	other place)	- 1	Date		ocation - City or To	own, State
permit. P Departme importan any joing		21. Signature of Funera Service (Icensee		ME. I	22	Name a	nd Address	y   08/2 of Facility Hebrew			lphi, MD e	
Physician		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused cause on each line	θ.					W, Wasł or respiratory	ningt arrest,	on, DC	Approximate Interval Between Onset and Death
ath certificate be executed attending physician and for use as the buriat-fransit	dical Examiner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last  d.	Due to (or as a	consequent	ce of):							
that the death certific led by the attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	c. ff yes, outcome of 1 Live birth 2 4 Pregnant at 1 9 Unknown	2 ☐ Fetaf dea	ath 3	Ectopic p	regnancy oecify)				23d. Date of detive	ery Day Year
quires that in signed by uld be deta	۾	Part II. Other significant conditions cont	ributing to death bu	t not resultin	g in the ur	nderlying	cause given	in Part I.		tobacco (		ne cause of death?
i: The law requir	Completed								24a. Wa aut per 1 🗆 Yes	opsy formed?	24b. Were auto prior to co death? 1 \( \sum \text{Yes}	psy findings available mptetion of cause of 2 No
ng Physi fter this c	ation; To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	spital: 1 XInpatier 28a. Date of Injun (Month, Day		Outpatien b. Time of fnjury		OA Other 28c. Injury a Work?	4   Nuising H		sidence	6 ☐Other (Special fy occurred	y)
tal or Attors after de al Diracto ed in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Pface of fnju building, etc	ry - At home . (Specify)	, farm, stre	eet, facto	y, office			(Street ar own, State	nd Number or Rura e)	al Route Number,
To the Hospital or Attendivitin 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai	29a. Certifier 1 X Certifying Physic (Check orlly one) 2 Medical Exemina		examination								
Mithi Com	Σ	29b. Signature and title of certifier	gu	1816	Div		c. License   045471				te signed (Month, gust 28,	
4		30. Name and address of person who son Yeheyis Negussie,					#214	Silver	Spring			
Stat Registra		31. Date filed (Month, Day, Year)	32. Pegistra	r's Signature	40	arte	,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 29440 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 29, August 2006 Michael David Gordon 7:42 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1995 Lancashire Drive Potomac Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June | 25, I Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 X M 2 □ F 56 Yrs. 1950 Director 209-42-6153 New York Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23e or 28e-f show eny july or other treumatic event, the Madical Evanthar must be notified at once. 1 XYes 2 No Directo Maryland Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1995 Lancashire Drive 20854 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: ģ 3 ☐ Widowed 4 💆 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Music Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jack Gordon Irma Levy ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keith Gordon / Brother 1995 Lancashire Drive; Rockville, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Parklawn Mem. Park 08/31/2006 Rockville, Maryland 21. Signature of Furtheral Servi 22. Name and Address of Facility Simple Tribute Funeral and Cremation Center 1040 Rockville Pike; Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that dused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Glioblastoma Multiforme 6 months /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Juisease or injury that initiated events Due to (or as a consequence of) Examiner use as the burial-transit resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical JF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 No 2 🗆 No 1 Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 2 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 XNatural М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

requires that the death certificate be executed Records, P.O. Box 68760 Division of Vital or Attending Physicien: after death, Director: After this certifica in by the funeral To the Hospitel within 24 hours a To the Funerel (

with the Maryland

Baltimore, Maryland 21215-0036

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

4 myomo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Victor M. Priego, M.D. 6420 Rockledge Drive #4100; Bethesda, Maryland 20817

D23308

8/29/2006

State Registrar

Medical

4 \( \text{Homicide} \)

31. Date filed (Month, Day, Year) AUG 31 2006



State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 2006 Glass August 9:10P M Catherine Sussette /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 13030 Coppermine Rd. Union Bridge Frederick 8. Date of Birth
(Month, Day, Year)
Jan. 28, 1928 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland **Funeral** 1 □ M 2 🖰 F 78 Yrs. Director 212-24-5827 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d, Inside City Limits Show ir than "natural", or items 23a or 28a-f show the Medical Expirimer must be notified at 1 TYes 2X No Directo Frederick Maryland Union Bridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13030 Coppermine Rd. 21791 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify: Specify: 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) farm wife/homemaker dairy/ own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be finent of Health and Mental Faut: If item 27 is marked of ဂ Guy Grover Garver Sadie Rippeon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Rice/ daughter 11924 Warner Rd. Keymar, MD 21757 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 △Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or Locust Grove Cemetery 8/28/2006 nr. Mt. Airy, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signalure al meral Service License 22. Name and Address of Facility Hartzler Funeral Home 11802 Liberty Rd. Libertytown, MD 21762 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** renal Carcinoma neck /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to it, in ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physicien and the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as the attending | IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death signed by the a d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2, No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes 2DENO 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5. Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death.

i Director: Aft d in by the fun 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Atterwithin 24 hours after des To the Funeral Director completely filled in by the 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 041619 Aug-st 25, 2006 Lerner MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Lerner 63 Thomas Johnson Dr., Ste. E Frederick, MD 21702 32/Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 9 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 2006 10:18 a M Harriet Heifetz August 24 Anne /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Aug 3 1949 Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Months Hours 1 ☐ M 2 🕱 F 451-90-3876 57 Yrs. Director Texas Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or Iteme 23a or 28e-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 🕅 🏋 o Director Columbia MD Howard 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 9417 Tall Window Way 21046 IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify ۵ 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedenl's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Trainer Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fit iment of Health and Mental H tent: If item 27 is marked ott Harold Simmons Gladys Vernon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) or other tra Aaron Heifetz (Husband) 9417 Tall Window Way, Columbia, MD 21046 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny injury or once. 8-27-2006 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Cemetery Annapolis, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Hardesty Funeral Home, P.A 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiralory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** mentho met astati /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ng physician and as the burial-transit The lew requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical ettending | IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the eld be detached for o 9 Unknown 9 Unknown <u>م</u> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Records. 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has the 1 ☐ Yes 2 No of Vital To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 05/16 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and little of certifier 29c. License number un of eath (Item 23a) (Type, Print) W. Charles St. Balts. Ul 2120x 15 6 3 6701 31. Date filed (Month, Day, Registrar's Signatur State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar 29444 Reg. No 2006 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day 2006 **Physician** 30, Asegedech Habte 1:12am M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Montgamery Washington Adventist Hospital Takoma Park If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Oct. 7, 1951 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2⊠F 54yrs Yrs. 226-51-1025 Director Ethiopia Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at ₩XYes 2 No Adelphi Director Prince Georges 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1836 20783 Ethiopia Metzerott Road Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if itsm 27 is marked other than "natural", or iten eny hiuty or other treumatic svent, the Medical Examiner page. 1 Yes 2 No If Yes, Give Year or Dates: 1√2Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Colonial Parking 8th Parking Attendant 17. Father's Name (First, Middle, Last) unk. 18. Mother's Name (First, Middle, Maiden Sumame) unk Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7930 Eastern Avenue, NW, Washington DC 20012 George Galatis (pastor) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery Sept. 5, 2006 Silver Spring, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7400 Georgia Avenue, NW McGuire Funeral Service, Inc. Indre Washington DC Suga pron 20012 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atherosclevotic Coronary Antery dise use **Physician** /Medical Examiner pertensive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due tol(dr as a consequence of) Examine ettending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 No Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the e Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Monknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22No certificate 1 ☐ Yes 2 ☐ No 1 Yes Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes 2 □ No Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{(Specify)} \) Certification: To 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ۾ 4 🗌 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the th 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 52326 August 31, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1300 Piccard Dene #202 Roderille, Mi 20850 300 MO Lennedy )amej 31. Date filed (Month, Day, Year) ∰eĝistrar's Signature State 2006 SEP 0 Registrar

	,		1- For Amend Item #1 State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Dep	rtment of Health and N		ene 9. No. 2 N N A	291.45
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Charles Edward Horn Charlie Edward Horn		2. Date of Death Month September	Dav Year	3. Time of Death
الر	Examin		4a. Facility Name (If not institution, give street and number)  Washington County Hospital  5. Social Security Number 6. Sex. 7. Age (In yrs. last birthday)	4b. Cily, Town, or Location of Death Hagerstown If Under 1 Year If Under 24 Hrs.	8. Date of Birth	4c. County of Death Washingto	on  Splace (State or Foreign
	Director		138-05-8370	Months Days Hours Min.	Oct 9, 1		erstown  10d. Inside City Limits
	th the Mary or 28a-f eh	irector	Maryland Washington Hagerston  10e. Street and Number	VN 10f. Zip Code	100	g. Citizen of What Cou	1 Tyes 2 No
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 le marked other than "natural", or itema 23a or 28a-f ehow any injury or other traumatic event, the Medical Examber must be motified at once.	d by Funeral Director	1 Never Married 2 Married 1 Yes 2 7/No	21742  Vas Decedent of Hispanic Origin? (Spyes, specify Cuban, Mexican, Puerto	ecify Yes or No-	S.A.  14. Race - Amer Black, White Specify: What	, etc.
Baltimore, Maryland 21215-0036	filed within 72 h Hygiene. ther than "natu nt, the Medical	Completed	(Specify only highest grade completed) (Give life. Lementary/Secondary (0-12) College (1-4or 5+)	ent's Usual Occupation and of work done during most of work O NOT use retired)  Body Technician	ing	Automotive	·
ırylan	should be ind Mental I	To Be	David Calvin Horn	Emma  g Address (Street and Number or Run	Stale	У	n Coda)
re, Ma	is 1 and 2 soft Health ar item 27 le other trau		Donald H. Horn / Son Elena  20a. Method of Disposition 20b. Place of Dispos	Dr. McDonough Ge	eorgia 30		
Baltimo	permit. Page Department of Important: If any injury or once.		4 Donation 5 Other (Specify)  21. Signature Funeral Service License  22.		st Haven		apel
	Physicien and American streets the partial-transit	dicai Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	r the mode of dying, such as cardiac ith in farition of re-trail Vessel da			Approximate Interval Between Onset and Death  CNL Week  5 Years
.O. Box 6	that the death certific ed by the attending p detached for use as	Physician/Mec		Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year
Records, P.	equires that en signed by ould be deta	5	Part II. Other significant conditions contributing to death but not resulting in the un Aserocarcinoma of the Stomach	derlying cause given in Part I.		cco use contribute to	
al Reco	n: The faw r ficete has be rr, pege 2 sh	e Completed	Genitorniany bleeding with sympitomate	espiratory failur		prior to co	opsy findings available impletion of cause of
Division of Vital	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death: within 24 hours after death: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Certification: To Be	27. Mann of Death 1 I latural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	3 □ DOA Other: 4 □ Nursing Ho	n (Check only one) me 5 ☐ Residenc 28d. Describe how	ce 6 Other (Speci	59)
D N	Hospital or Att	i Certifi	4 Homicide determined building, etc. (Specify)		City or Town, S		
	To the Hos within 24 ho To the Fun completely i	Medical	29a. Certifier (Check only one)  1 Queftifying Physician: To the best of my knowledge, death and manner stated.  2 Medical Examiner: On the basis of examination and/or invited and manner stated.	occurred at the time, date and place, estigation, in my opinion, death occurr	ed at the time, date	se(s) and manner as s a and place, and due t I. Date signed (Month,	o the cause(s)
	r s r o		Robe J Brull UD PCV5 (Mal Mysician 30. Name and address of person who completed cause of death (Item 23a) (Type, F	(rint) (1) 0004:	359	Sep 4	2006
3	Sta Registr		31. Date filed (Month; Bay: Year)  SEP 0 6 2006  SEP 0 6 2006	(VId - Kobent B)	noll MU		

		•	1 - For State Registrar	State of Maryla	nd / Depa <i>Cer</i>	rtment of Health an tificate of Death		iene 2006	29446
	Physici /Medio		1. Decedent's Name (First, Middle, Last, William	n c. f	top50		2. Date of Deat	29/2000	
	Examir Funeral Director	er	4a. Fecility Name (If not institution, give  2317 F May berr  5. Social Security Number 6. Security Number 12  218 - 32 - 8321  Usual Residence of Decedent	v Road	s. last birthday) Yrs.	4b. City, Town, or Location of E	Hrs. 8. Date of Birth (Month, Day,	4c. County of Dea Car Year) 9. Bir 10, 1934	roll hhplace (State or Foreign unitry) N. Carolin
	anylane ehow		10a. State 10b. County		City, Town or Lo				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the Ma	ecto	MD Carr  10e. Street and Number	011	Westmi	nster 101. Zip Code	11	Og. Citizen of What Co	
nd 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Heelih and Mentai Hygiene. If item 27 ie marked other then "neturel", or iteme 23a or 28a-1 ehow or other traumatic event, the Medical Examinar must be notified at	Be Completed by Funeral Director	2317 F. Mayberr  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest graded)  Elementary/Secondary (0-12)  10  17. Father's Name (First, Middle, Last)	12. Was Decedent Ever in Armed Forces?  1 ☑Yes 2 ☐ No If Yes, Give 1 960 cation	16a. Deced	21158 Vas Decedent of Hispanic Origin' Yes, specify Cuban, Mexican, P  Yes 2 No Specify:  ent's Usual Occupation kind of work done during most of NOT use retired)  Clerk  18. Mother's		14 Race Ame Black, Whit Specify: 16b. Kind of Business Retail Maiden Surname)	e, etc.
/lar	Vienta be Menta Mrked Artic ev	<b>B</b> 0	Jason Hopson			Pea	arl Camph	۵1.1	
Maryland	12 sho h end 7 ie mu traum		19a. Informant's Name/Relationship (Ty Ruth Hopson-Wii	*		Address (Street and Number o			
altimore, I	0 5 5 >		20a. Method of Disposition  1 Durial 2 Cremation 3 F  4 Donation 5 Other (Specify)	20b.	Controlory, Croin		Rd. Wes 11/06 netery	tminster 20c. Location - City or leasant N	MD 21158 Town, State Valley, MD
Balt	permit. F Depertme importar any injur		21. Signature of Funeral Service Licens	Potele J.		Name and Address of Facility  ttle 's FH 34  r the mode of dying, such as cer	Maple A	ve littl	17340
	/Medical Examiner	Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Finat disease or condition resulting in death)  Sequentially list conditions, flary, leading to ammediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of):	r the mode of dying, such as cer	diac or respiratory arre	st,	Approximate Interval Between Onset and Death
68760,	ficate be executed physicien and s the burial-transit	edical Ex	resulting in death) Last	Due to (or as a conse	equence of):				
P.O. Box 6	deeth certi e ettending ed for use e	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tel death 3 □	Ectopic pregnancy Other (specify)		23d. Date of deli Month	very Day Year
	iaw requires that the es been signed by th 2 should be deteche	Ď	Part II. Other significant conditions cor	tributing to death but not re	esulting in the un	derlying cause given in Part I.		acco use contribute to s 2 No 3 Pro	the cause of death?
of Vital Records,	The ete h	e Completed	25. Was case referred to medical			26 Place of	24e. Was an autopsy perform 1 Yes 2	ed? prior to death?	topsy findings available completion of cause of
Ţ	d is	ToB	evaminer?	ospital: 1 Inpatient 2[	☐ ER/Outpatient	0.1	g Home 5 Resider	-	sify)
Division o	After	Certification;	27. Manper of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how	w injury occurred	
DIV	sital or Att		4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	eify)		City or Town,		
1	To the Hospital or Attent within 24 hours effer deatl To the Funeral Director: compiately filled in by the	Medical	(Check only 2   Medical Examil	ician: To the best of my kner: On the basis of examinand manner stated.	nowledge, death nation and/or invi	occurred at the time, date and plestigation, in my opinion, death o	ccurred at the time, da	te and place, and due	to the cause(s)
	\n\ F\$€		29b. Signature and title of certifier	ine greet	M.O	29c. License number		d. Date signed (Month	29, 2006
~ L	15 Sta	te	30. Name and address of person who co	mpleted cause of death (Ite	ner An	rint) R. Svite 30	7 vestm	inster M	021157
	Registr		AUG 3 1 20	06 Streve	K A	arli			

CHARLES R. HEWES  4a. Facility Name (If not institution, give street and number)  111 FARMDALE ROAD  4b. City, Town, or Location of Death  111 FARMDALE ROAD  5. Social Security Number  22 16 5762  Usuel Residence of Decedent  10a. State  10b. County  10c. City, Town or Location  4b. City, Town, or Location of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. Co		1 State Registrar  1. Decedent's Name (Fire	st, Middle, La			Ce	rtificate	of Deat	h	fental Hyg	leg. No.		3. Time of De
11 FARMDALE ROAD  11 FARMDALE ROAD  12 Social Security Number  13 Social Security Number  14 Social Security Number  15 Social Security Number  16 Social Security Number  17 Social Security Number  18 Social Security Number  18 Social Security Number  19 Social Security Number  19 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  11 Social Security Number  12 Social Security Number  13 Social Security Number  14 Social Security Number  15 Social Security Number  16 Social Security Number  17 Social Security Number  18 Social Security Number  18 Social Security Number  19 Social Security Number  19 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Security Number  10 Social Se		CHARLES	R.		HEWES								1.
Social Security Number   C. Sex   7. Agr (in ym. sex brinnay)   Florey 1 year   11/16/20 2   18.2.   Date of Bigm   DELAWARE   2.2.   List of Bigm   DELAWARE   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19.2.   10.5   19		4a. Facility Name (If not	institution, gi	ve street and nu	ımber)		4b. City, To	wn, or Locatio	n of Death		4c.	County of De	eath
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SANUEL HEVES  SANGELINE P. HEWES  19a. Informant's Nama-Pielationship (Type, Pirot)  ANGELINE P. HEWES  111 FARMDALE ROAD, EARLEVILLE, MD 21919  20a. Mailting Address (Street and Number or Pival Route Number, City or Town, State, Zip Code)  112 Lindon Supposition  113 Lindon Supposition  20b. Place of Disposition (Name of Committee)  114 Lindon Supposition  215 Synature Frank, Victor (Name of Committee)  216 Lindon Supposition  217 Synature Frank, Victor (Name of Committee)  218 Lindon Supposition  219 Lindon Supposition  219 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Lindon Supposition  210 Li				1 V Wes If Yes, G	2 □ No ive		1 ☐ Yes 21	No Speci	fy:			Specify:	WHITE
SANUEL HEWES  19b. Mailing Address (Street and Number or Plural Route Number, City or Town, State, Zip Code)  11c. Informatis Name-Relationship (Type, Print)  11d. Informatis Name-Relationship (Type, Print)  11d. Informatis Name-Relationship (Type, Print)  11d. Informatis Name-Relationship (Type, Print)  11d. Informatis Name-Relationship (Type, Print)  11d. Informatis Name-Relationship (Type, Print)  11d. Informatis Name-Relationship (Type, Print)  11d. Informatis Name-Relationship (Type, Print)  11d. Informatis Name-Relationship (Type, Print)  11d. Informatis Name-Relationship (Type, Print)  11d. Informatis Name-Relationship (Type, Print)  11d. Informatis Name-Relationship (Type, Print)  11d. Informatis Name-Relationship (Type, Print)  11d. Informatis Name-Relationship (Type, Print)  11d. Informatis Name-Relationship (Type, Print)  11d. Informatis Name-Relationship (Type, Print)  11d. Informatis Name-Relationship (Type, Print)  11d. Informatis Name-Relationship (Type, Print)  11d. Informatis Name-Relationship (Type, Print)  11d. Informatis Name-Relationship (Type, Print)  11d. Informatis Name-Relationship (Type, Print)  11d. Informatis Name-Relationship (Type, Print)  11d. Informatis Name-Relationship (Type, Print)  11d. Informatis Name-Relationship (Type, Print)  11d. Informatis Name-Relationship (Type, Print)  11d. Informatis Name-Relationship (Type, Print)  11d. Informatis Name-Relationship (Type, Print)  11d. Informatis Name-Relationship (Type, Print)  11d. Informatis Name-Relationship (Type, Print)  11d. Informatis Name-Relationship (Type, Print)  11d. Informatis Name-Relationship (Type, Print)  11d. Informatis Name-Relationship (Type, Print)  11d. Informatis Name-Relationship (Type, Print)  11d. Informatis Name-Relationship (Type, Print)  11d. Informationship (Type, Print)  11d. Informationship (Type, Print)  11d. Informationship (Type, Print)  11d. Informationship (Type, Print)  11d. Informationship (Type, Print)  11d. Informationship (Type, Print)  11d. Informationship (Type, Print)  11d. Informationsh	å p				Dates:1946	16a Dec	adente Heual (	Occupation			16h Kir	nd of Busines	se/Industry
SANUEL HEWES  19a. Informant's Name-Relationship (Type, Print)  11 FARMDALE ROAD, EARLEVILLE, MD 21919  20a. Markhod of Disposition  1.0 Burdle 20Crownation 3 Removal from State  1.0 Burdle 20Crownation 3 Removal from State  1.1 Burdle 20Crownation 3 Removal from State  1.2 Burdle 20Crownation 3 Removal from State  1.2 Burdle 20Crownation 3 Removal from State  1.3 Burdle 20Crownation 3 Removal from State  1.4 Donation 5 Removal from State  1.5 Burdle 20Crownation 5 Removal from State  1.5 Burdle 20Crownation 5 Removal from State  1.5 Burdle 20Crownation 5 Removal from State  1.6 Burdle 20Crownation 5 Removal from State  1.7 Burdle 20Crownation 5 Removal from State  1.8 Burdle 20Crownation 5 Removal from State  1.9 Burdle 20Crownation 5 Removal from State  1.1 Burdle 20Crownation 5 Removal from State  1.2 Burdle 20Crownation 5 Removal from State  1.2 Burdle 20Crownation 5 Removal from State  1.2 Burdle 20Crownation 5 Removal from State  1.3 Burdle 20Crownation 5 Removal from State  1.4 Burdle 20Crownation 5 Removal from State  1.5 Burdle 20Crownation 5 Removal from State  1.6 Burdle 20Crownation 5 Removal from State  1.7 Burdle 20Crownation 5 Removal from State  1.8 Burdle 20Crownation 5 Removal from State  1.9 Burdle 20Crownation 5 Removal from State  1.0 Burdle 20Crownation 5 Removal from State  1.0 Burdle 20Crownation 5 Removal from State  1.0 Burdle 20Crownation 5 Removal from State  1.0 Burdle 20Crownation 5 Removal from State  1.0 Burdle 20Crownation 5 Removal from State  1.0 Burdle 20Crownation 5 Removal from State  1.0 Burdle 20Crownation 5 Removal from State  1.0 Burdle 20Crownation 5 Removal from State  1.0 Burdle 20Crownation 5 Removal from State  1.0 Burdle 20Crownation 5 Removal from State  1.0 Burdle 20Crownation 5 Removal from State  1.0 Burdle 20Crownation 5 Removal from State  1.0 Burdle 20Crownation 5 Removal from State  1.0 Burdle 20Crownation 5 Removal from State  1.0 Burdle 20Crownation 5 Removal from State  1.0 Burdle 20Crownation 5 Removal from State  1.0 Burdle 20Crownation 5 Removal from	jet	(Specify or	nly highest gr	rade completed,		(Giv	DO NOT use	done during m retired)	ost of work	king	100. 10	10 01 00311103	Samuastry
SAMUEL HEVES  SAMUEL HEVES  19a. Informant's Nama-Pielationship (Type, Pint)  ANGELINE P. HEWES  111 FARMDALE ROAD, EARLEVILLE, MD 21919  20a. Maind of Disposition  112 Binarial 220c-branation 3   Parmoval from State    113 Enformant's Nama-Pielationship (Type, Pint)  214 Binarial 220c-branation 3   Parmoval from State    115 Binarial 220c-branation 3   Parmoval from State    116 Binarial 220c-branation 3   Parmoval from State    117 Binarial 220c-branation 3   Parmoval from State    118 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory areast, inherent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory areast, inherent disease or conditions in the cause of the death    220 Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binaria 20c Binari	Eo		y (0-12)	College	(1-40r 5+)	PAIN	TING CO	NTRACT	OR		PA	TNTTNG	ļ
SANUEL HEVES  19a. Intermed Name-Relationship (Type, Print)  19b. Mailing Address (Street and Number, City or Town, State, Zip Code)  111 FARMDALE ROAD, EARLEVILLE, MD 21919  20b. Method of Disposition 11 Cleared 2 20brension 3 Commenced of Date 12 Cloared 2 20brension 3 Commenced of Date 13 Cloared 2 20brension 3 Commenced of Date 14 Cloared 2 20brension 3 Cloared State 15 Cloared State 16 Cloared 2 20brension 3 Cloared State 17 Cloared 2 20brension 3 Cloared State 18 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared State 19 Cloared	0	17. Father's Name (First	, Middle, Las	t)						e (First, Middle,			
195. Maling Address (Street and Number of Puzzi Pout Aumber, City or Town. State Zip Code)  20a. Method of Disposition 1		SAMUEL HE	EWES						BEAT	RICE LUI	DWIG		
20a. Method of Disposition 1   Burial   20K Framation   3   Permission   3   Permission   3   Permission   1   Permission   4   Donation   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5   Cherrison   5													
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PO BOX 2866   WILMINGTON DE 19805					FAM			IN	1	- 1	WI	LMINGT	ON. DE
THARLES F. MEALEN JR.  22a Part First the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory areal.  Approximately list conditions, and the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the c		21. Signature of Funera	Service Lice	nsee	2	2	2. Name and A MEALEY	Address of Fac FUNER	AL HO	MES			
Per   In   Per   20   Was decedent pregnant in the past 12 morths?   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   23d. Da	Examiner	if any, leading to immed cause. Enter Underlying Cause (Disease or injury that initiated events	liate III	Due to									
24a. Was an autopsy performed? 1   Yes 2   No 3   Probably 4    24a. Was an autopsy performed? 1   Yes 2   No 1   Probably 4    25. Was case referred to medical examiner? 26. Place of Death (Check only one)  27. Manner of Death 1   Inpatient 2   ER/Outpatient 3   DOA    28b. Time of Injury at Work? 2   Accident 3   Suicide 4   Homicide    28c. Place of Death (Check only one)  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how inju	ed	23b. Was decedent pre- in the past 12 mon	ths?	1☐Live 4⊡Preg	binth 2 ☐ Feta nant at time of d	I death 3					2		
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24a. Was an autopsy performed?    24a. Was an autopsy performed?   24b. Were autopsy finding prior to completion of death?   25c. Was case referred to medical examiner?   25c. Was case referred to medical examiner?   25c. Was case referred to medical examiner?   25c. Was case referred to medical examiner?   25c. Was case referred to medical examiner?   25c. Value of Death (Check only one)   25c. Value of Death (Check only one)   25c. Value of Death (Check only one)   25c. Value of Death (Check only one)   25c. Value of Death (Check only one)   25c. Value of Death (Check only one)   25c. Value of Death (Check only one)   25c. Value of Death (Check only one)   25c. Value of Death (Check only one)   25c. Value of Death (Check only one)   25c. Value of Death (Check only one)   25c. Value of Death (Check only one)   25c. Value of Death (Check only one)   25c. Value of Death (Check only one)   25c. Value of Death (Check only one)   25c. Value of Death (Check only one)   25c. Value of Death (Check only one)   25c. Value of Death (Check only one)   25c. Value of Death (Check only one)   25c. Value of Death (Check only one)   25c. Value of Death (Check only one)   25c. Value of Death (Check only one)   25c. Value of Death (Check only one)   25c. Value of Death (Check only one)   25c. Value of Death (Check only one)   25c. Value of Death (Check only one)   25c. Value of Death (Check only one)   25c. Value of Death (Check only one)   25c. Value of Death (Check only one)   25c. Value of Death (Check only one)   25c. Value of Death (Check only one)   25c. Value of Death (Check only one)   25c. Value of Death (Check only one)   25c. Value of Death (Check only one)   25c. Value of Death (Check only one)   25c. Value of Death (Check only one)   25c. Value of Death (Check only one)   25c. Value of Death (Check only one)   25c. Value of Death (Check only one)   25c. Value of Death (Check only one)   25c. Value of Death (Check only one)   25c. Value of Death (Check only one)   25c. Value of Death (Check only one)   25c. Value of		Part II. Other significan	1	40	death but not res	ulting in the	underlying cau	se given in Pa	π ι.		_	_/	
25. Was case referred to medical examiner?    1   Yes   2   No		ICCITI 1	UIT NO	11419	PAUSO	2011	.)			, ,	65 29	K1140 2 1	1 Tobacily 4 Golff
25. Was case referred to medical examiner?  1		hypertens	iun							autop perfor	sy med?	prior to death?	o completion of caus
27. Manner of Death   Natural   S   Pending   Injury   M   Describe   Pending   Injury   M   Pending   Pending   Injury   Pending   Injury   Pending   Injury   Pending   Injury   Pending   Injury   Pending   Injury   Pending   Injury   Pending   Injury   Pending   Injury   Pending   Injury   Pending   Pending   Injury   Pending   Pending   Injury   Pending   Pending   Injury   Pending   Pending   Pending   Injury   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending   Pending		25. Was case referred t	o medical	Hospital:				Other		1	пе)		
2   Accident 3   Suicide 4   Homicide   See. Place of injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural R	Be Completed			1 C				40	Nursing Ho				pecify)
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29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	To Be Completed	examiner? 1 Yes 2 No  27. Manner of Death 1 Natural 5	☐ Pending	(Moi	nth, Day Year)								
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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

06-06770 Debbie Hoopes

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death Registrar  Certificate of Death	Reg. No. 2006 2941
Physici ledical Exam		1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day September 8, 2006  3. Time of Death 1240 hrs
and to be		Debbie Dianne Hoopes  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location	Ocptember 6, 2000
. i		Upper Chesapeake Medical Center Belair	Harford
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs last birthday) If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year	der 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Alabama
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ie e	Director	10e. Street and Number 10f. Zip Code 21009	10g. Citizen of What Country?  USA
with th 18 23a 9e notii		11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Or	igin? ( Specify Yes or No- 14 Race - American Indian, Black,
r death or iten	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexica 1 Yes 2 No	
rs after ural",	by	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specification (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give	
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15-0036 Filed within 72 h Hygiene d other than "i	dwc	3 LPN Nurse	Health Care  or's Name (First, Middle, Maiden Surname)
:15-( e filed al Hyg ced oth	Be Co		ge G. Holtz
7 a 8 a 8	To E		umber or Rural Route Number, City or Town, State, Zip Code)
ore, MD 2 ss 1 and 2 shou of Health and N If item 27 is r her trammatic		David J. Smith / Father 301 Akin Terace,  20a Method of Disposition (Name of cemeter).	Abingdon, Maryland 21009  Date   20c. Location - City or Town, State
2		1 XBurial 2 Cremation 3 Removal from State crematory or other place)	
Baltimo permit Page Department ( Important: injury or oth	9	4 Donation 5 Other Specify Highview Memorial Gro	
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/Medical Examiner	100	Immediate Cause (Final disease or condition resulting in death)  a. Alcohol and zolpidem intoxication compl	icated by drowning Death
		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.	
	iner	if any, leading to immediate Due to (or as a consequence of):	
gad.	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of)	
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	ledical	X UNPENDED terr#23a,27,28a-f,perME,g860,10/	2/06 TT
8760, rifficate be ring physici as the burn	3	23b. Was decedent pregnant in the	
Box 687  e death certifi  the attending  ed for use as t	Physiciar	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify)	
D. Be t the de by the			Part I. 23e Did tobacco use contribute to the cause of death?
, P.O res that t signed by	d by		1 Yes 2 No 3 Probably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law requirers after death and Directors. After this certificate has been seled in by the bineral director, page 2 should I	Completed		24a Was an autopsy findings available prior to completion of cause of
Recol The law cate has	mo		performed? death?  1 ✓ Yes 2 No 1 ✓ Yes 2 No
tal Rection: The certificate ector, page	Be C	25. Was case referred to medical 25. Place of Deat	h (Check only one)
f Vit Physic er this ral dir	မ	1 Ves 2 No 1 Inpatient 2 En/Outpatient 3 DOA 4	Nursing Home 5 Residence 6 Other:
ion o tending eath tor: Aft the fune	ţi ii	27. Manner of Death 28a. Date of Injury 1 Natural 5 Pending Fnd 9/8/2006 28b. Time of Injury 28c. Injury at Wo	7 1
ivision or Attenu after death Director:	ifica	2 Accident Investigation 3 X Suicide 6 Could not be 6 Could not be	etc. 28f. Location (Street and Number or Rural Route Number, City
Divipital of ours at filled	Certification:	4 Homicide determined (Specify) found at home	Abindon, MD 519 Kirk Caldy Way
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Finneral Director. After this certificate has been signed by the attending physici completely filled in by the finneral director, page 2 should be deached for use as the buri	edical		place, and due to the cause(s) and manner as started occurred at the time, date and place, and due to the cause(s)
To 1	Med	and manner stated  29b Signature and title of certifier  29c License number	
		0.C.M.E.	September 10, 2006
		30. Name and address of person who completed cause of death (Item 23a)	L
		Jack Titus MD.    ✓ Deputy Chief Medical Examiner 111 Penn Street, Baltimore	, MD 21201
S Regis	State	OF D. 3. C. /1111b   478/48, 44 4 445 48868 75	
Negl	માલ	ULI A V I	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Joseph Daniel Hamilton /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALLIMUSE CIT he Johns Hupkins Hospital 5. Social Security Number 6. Sex 1**X** M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min. Hours Director Aug 31 Maryland 2006 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or iteme 23a or 28a-f ehow the Medical Examinar must be notified at Yes 2 No Funeral Director Hagerstown N/A 10e. Street and Number N/A10f. Zip Code 10g. Citizen of What Country? 113 Broadway Apt. 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: White 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) N/AN/A N/A17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be lik Department of Health and Mental Hy Important: if Item 27 is marked oth any linjury or other traumatic event 9008: 18. Mother's Name (First, Middle, Maiden Sumame) Larry Hamilton Virginia Gail Cline 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Gail Cline (mother) 113 Broadway Apt. 3 Hagerstown Maryland 21740
e of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Smithsburg Crematory 9-2-2006 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown Maryland 21742 nuncon. XUN Approximate
Interval Between
Onset and Death
Cohrs. 39mins 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Prematurity **Physician** Extreme /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): led by the attending physicien and detached for use as the burial-transit Due to (or as a consequence of): DIVISION OF THE IN G. P.O. Box 68760, Completed by Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 21 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerel ( Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D62901 30. Name and add-s of person who completed cause of death (Item 23a) (Type, Print) Alice Chung 2H-0 (OD N. Wolfe strar's Signature Baltimore, Maryland Cootauco 31. Date filed (Minth, Day, Year) 32. Registrar's Signature State Registrar

**ORIGINAL** 

06-06387 John Walter Jameson

## Please Type or Print in Black Indelible Ink

n Walter Jar		1- For State Registrar	tate of Maryland		tificate of		and	wienta:		Re	9-710-	200		45
Physici dical Exam		1. Decedent's Name (First, Midd John Walter Ja							1 1	Date of Deat Month ugust 26	Day	Year	3. Time of Death 0745 hrs	n
		4a. Facility Name (if not institution 1002 Boom Court		er)	4	b. City, Tow Annapo		cation of D		- <del></del>	4c. Cou	nty of Death	1 <u>.                                    </u>	
Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. la	ast birthday)	If Under 1	Year	If Under 2		Date of Birt			thplace (State or	
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v any		10a. State 10b. County		10c. City,	Town or Location	on		<u> </u>		<del></del>			10d. Inside City	
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h the Ma 3a or 28		1002 Boom Cour				2140					USA			
eath wit items 2	uneral	11. Marital Status  1 Never Married 2 X	12. Was Decede Armed Force 1 X Yes			s Decedent es, specify C				y Yes or No- an, etc.)		Race - Amer Vhite, etc.	can Indian, Black	ζ,
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5-0036 iled within 7 Hygiene I other than	omo	6 17. Father's Name (First, Middle	e, Last)		Truck 1	Driver		Mother's N	Name (Fir	st, Middle, N	Brewe		mpany	
21215 21215  build be filee I Mental Hy marked o	Be C	John Jameson 19a. Informant's Name/Relation	T. P. D.		Landana					Chris				
MD 2 nd 2 shoul alth and M m 27 is m	입	John W. Jameso		n	19b. Mailing 36880									
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition  1 X Burial 2 Cremation	on 3 Removal from		Place of Disposi prematory or oth Mary I		of cemet			ite			Town, State	
Baltimore, permit Pages 1 an Department of Hea Important: If iter injury or other tra		4 Donation 5 Other S 21. Signature of Funeral Service			terans (	Cemete	ery dress of	Facility R	08/29 Rober	/2006 t E.	Chelt Evans	enham Funer	al Home	
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Physician /Medical Examiner		failure. List only one cause Immediate Cause (Final disease	e on each line.				, mg, 54	on do odra	10001100	prictory circ	ost, orlook, o	ricar	Between Onse Death	
		or condition resulting in death)	Due to (or as a co	nsequence of	f):									
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Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. The law requires that the funeral Director: After this certificate has been signed by the attending physician and appliedy filled in by the funeral director, page 2 should be detached for use as the burial - transit	ician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	the 23c. If yes, out			tal death	3	Ectopic pr	regnancy		23d. Dat Mont	te of deliver th I	/ Day Yea	ar
Box 687  death certific  the attending p	Physici		14 Pregnant Pregnant Pregnant Pregnant	t at time of de n	ath 5 Oth	ner (Specify	)							
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rds, l requires been sig		Dementia							-	24a. Was a	an 2	4b. Were au	topsy findings av	ailable
of Vital Records, ag Physician: The law requir ther this certificate has been s meral director, page 2 should 1	Completed									perfor	med?	death? 1 ✔ Ye		No No
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Division tal or Attendir rs after death. al Director: △	Certification:	2 Accident Inve	estigation 28e. Place o	f Injury - At ho	ome, farm, stree	et, factory, of		ding, etc.				umber or Ru	ral Route Numbe	er, City
Diversal o	Certi	4 Homicide dete	ermined (Specify)							or Town, S				
Divisior  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only	Physician: To the best of aminer: On the basis of e and manner state	examination a										
F 3 F 8	Me	29b. Signature and title of certif		000	7 :		icense n					signed (Mo	nth, Day, Year)	
		30. Name and address of perso	n who completed cause	of death (Item	23a)	`					/ lugust		<del>-</del> ,	
2+1			ssistant Medical Ex	kaminer strar's Signatu	111 Penn S	Street, Ba	Itimore	e, MD 2	1201				<u> </u>	
Regis	state	4110 0	9 2006	Sur 3 Orginall	N 1	W								

State of Maryland / Department of Health and Mental Hygiene 200629451 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 2006 Robert James Keppinger Sept 08 9:42 pm /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford 4160 U Way Havre de Grace 8. Date of Birth (Month, Day, Year) 06/02/1927 Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1X1M 2□ F Maryland 79 213-28-7723 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County rai', or items 23a or 28a-f show Exeminer must be notified at 1X Yes 2 □ No MD Havre de Grace Harford Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21078 4160 U Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: WW I I 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Bleck, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married 10 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White þ 3 ₩idowed 4 □ Divorced "natural" Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th other than College (1-4or 5+) Team Leader Preventive Maint. U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event Be Matthew Keppinger Olive Riale 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4160 U Way. Havre de Grace. Robert M. Keppinger- Son MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford Mem. Grdns. 09/13/06 Aberdeen, Maryland 21. Signature of Funeral Service Licensee 3000 123 S. Washington, Havre de Grace, roune r MD 21078 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death node of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical ue to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transi resulting in death) Last been signed by the attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: me of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy I ive hinh Month Year Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by should be 4 Donknown 2 No 3 Probably Were autopsy findings available prior to completion of cause of death?

1 Yes No 24a. Was an 24b. has autopsy this certificate 1 Tyes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only Medical Certification: To Be one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1 🗌 Y98 27. My er of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Injury 5 Pending investigation Natural 2 No 1 ☐ Yes 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the use of death (Item 23a) (Type, Print) 31. Date filed (Month State 5 2006 Registrar

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	~	ST. VINCENT DE PA	UL NURSING CI	ENTER	FROSTBURG			ALI	LEGANY	
. Funer Direct		214-12-3184	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day I-15-I	919	9. Birthpl MARYI	ace (State or Foreign LAND
land ow	E	Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or Lo	ocation				10	Od. Inside City Limits
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Itimo it. Pa rtmen rtant: njury		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens			G MEMORIA		-12 <b>-</b> 06 <b>F</b>	ROSTE	BURG, MD	STREET
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Division of Vita Withe Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifics completely filled in by the funeral director.	edical (	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of my kr ner: On the basis of examir and manner stated.	nowledge, deat nation and/or in	h occurred at the time vestigation, in my op	e, date and place, inion, death occur	and due to the c red at the time, d	ause(s) an ate and pla	nd manner as sta ace, and due to	ated. the cause(s)
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6		30. Name and address of person who co	dhy = 5	>t. V	incent	De	Paul	Nur	sing	(2,2006 Center
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DHMH 17 Rev 1/2001

Registrar

/Medic	an	Decedent's Name (First, Middle, Last  KATHLEEN CH.		LOCK			2. Date of De.	ath Day	Year	3. Time of Death 22: 48 M
Examin		4a. Facility Name (If not institution, give		e te	4b. City, Town	n, or Location of De	ath	4c. Count	y of Death	22, 70
uneral irector		221-42-0785		rs. last birthday, Yrs.	If Under 1 Ye Months Da			y, Year)	Coun	lace (State or Foreig try) BORO, DE
fed at	Į.	Usual Residence of Decedent  10a. State 10b. County  DELAWARE SUSSEX		City, Town or L					1	0d. Inside City Limit
r 28a	Director	10e. Street and Number			10f. Zip Cod	8		10g. Citizen of	What Coun	try?
23a	a la	227 HUB COURT,	WEST		199	966		UNITE	ED STA	TES
item 27 is marked other than "natural", or itams 23s or 28s-f show other traumatic event, the Modical Exercities must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of If Yes; specify C	uban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)		ce - Americ ack, White, of the WHI	etc.
en "natur Medical I	Completed	15. Decedent's Edd (Specify only highest grad		(Give	dent's Usual Oc kind of work do DO NOT use rel	ne during most of v	vorking	16b. Kind of B	Business/Inc	dustry
	S	12	1	RE.	AL ESTAT	TE AGENT		REAL E	ESTATE	SALES
ie marked oth raumatic event	To Be	17. Father's Name (First, Middle, Last)  WILLIAM B. CH.	,			STELL				
7 ie m traum		19a. Informant's Name/Relationship (7)		1			Rural Route Numbe			Code)
em 27 ther tr	1	JOSEPH A KOLLOC		. Place of Dispo	BOX 68		ORO, DELA	20c. Location		wn. State
n: If it y or o		1 ■ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State	cemetery, cre RINCE G	matory`or other ( EORGES (	olace) l	P 03,2006			DELAWARE
important: If its any injury or ot once.		21. Signature of Funeral Service Licens	see / A	CEMEI	P.K.Y 2. Name and Ad VATSON F	dress of Facility	OME		,	
sician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition	cations that caused the done cause on each line.	eath. Do not en	ter the mode of o		iac or respiratory as	rest, ·		Approximate Interval Between Onset and Death
ohysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. UAAD Due to (or as a cons b. UAD Due to (or as a cons c. Due to (or as a cons	equence of):						
been signed by the attending physic should be detached for use as the bi	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	d.  23c. If yes, outcome of pre- 1 Live birth 2 F 4 Pregnant at time of	etal death 3	⊒Ectopic pregna ∃ Other (specify,				ate of delive	ry Day Year
ned e det	Completed by P	Part II. Other significant conditions co		resulting in the u	nderlying cause	given in Part I.		obacco use con ∕es 2□No	tribute to th	e cause of death? ably 4 Munknow
en sig buld bu	piet							rmed?	prior to con death?	osy findings availab apletion of cause of 2 No
cate has been sign , page 2 should be	Com					26 Place of D	eath Check only o			
certificate has been sig rector, page 2 should be	Be	25. Was case referred to medical examiner?	Hospital:			<b>34</b>	- The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the			.1
: After this certificate has been sig funeral director, page 2 should be	To Be	examiner? 1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpatient 2 28a. ate of Injury (Month, Day Year	ER/Outpatier	f 28c. lr	<b>34</b>	Home 5 Resid			)
<b>Director:</b> After this certificate has in by the funeral director, page 2	To Be	examiner? 1   Yes 2   No   1	28a. ate of Injury	28b. Time of Injury	f 28c. lr	Other: 4 Nursing		now injury occur	rred	
Director: After this certificate has in by the funeral director, page 2	Certification; To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined	28a. ate of Injury (Month, Day Year) 28e. Ptace of Injury - A	28b. Time of Injury  I home, farm, stricity)	f 28c. Ir	Other: 4 Nursing	28d. Describe h	Street and Numi on, State)	ber or Rural	Route Number,
ctor: After this certificate has y the funeral director, page 2	To Be	examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined  29a Cartifier (Check only one)  29b. Signature and title of certifier	28a. Place of Injury - A building, etc. (Spe	28b. Time of Injury  t home, farm, streify)  included deal ination and/or in	f 28c. In M 1 reet, factory, office vestigation, in m 29c. Lice	Other 4 Nursing Nursing Nury at Nork? Yes 2 No	28d. Describe h  28f. Location (S  City or Tow  ce, and due to the curred at the time, (	Street and Numin, State)  aueu(e) and midate and place,	ber or Rural and of ac sta	Route Number, sted. the cause(s)

			1 - For State Registrar			nd / Depa	artmer		ealth and	Mental Hy			201.55
	Physici		1. Decedent's Name (First, Middle,							2. Date of De Month	ath Day	Year	3. Time of Deam
	/Medic Examir		Judith Levi  4a. Facility Name (If not institution,		r)		4b. City	, Town, or	Location of Dea	August		County of Death	3:30AM M
			15301 Wallbrook	Ct. Apt.	2G		1		pring		Mor	ntgomery	
	Funeral Director		5. Social Security Number 215–46–3356  Usual Residence of Decedent	5. Sex 7. A 1 ☐ M 2 🖾 F	ige (In yrs.	/ast birthday) Yrs.	If Unde Months		If Under 24 Hr. Hours Min		v. Year)	9. Birthp Cour Wash	olace (State or Foreign otry) ington, DC
	ryland how		10a. State 10b. County			ty, Town or Lo						1	0d. Inside City Limits
	Ba-f s	ecto	MD Montgo	omery	Sil	ver Spi							1X Yes 2 □ No
	with t	Funeral Director	10e. Street and Number 15301 Wallbrook	Ct. Apt. 2	2G			0906				en of What Cour	ntry?
	death	nera	11. Marital Status	12. Was Deceden	t Ever in U	I.S. 13.	Was Dece	dent of Hi	spanic Origin? (	Specify Yes or No rto Rican, etc.)	- 1	4. Race - Americ	
Maryland 21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or iteme 23s or 28s-1 show its Madical Exeminar must be rigitined at	þ	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced		]No	1		2 [™] No		no Hican, etc.)		Black, White, Specify: Wh	^{etc.} nite
<u>5</u>	n 72 h "natu	lete	15. Decedent's (Specify only highest	grade completed)		16a. Dece	kind of wo	al Occupa	tion uring most of we	orking	16b. Kin	d of Business/Ind	dustry
7	d withi	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	5+)	Educa		136 16(1160)			Sc	chool Sy	stem
밀	al Hyg	Bec	17. Father's Name (First, Middle, La	*		<u>'</u>				me (First, Middle,			
<u>Y</u>	ould t	2	Harry Max Levine	100000000000000000000000000000000000000						a Vernor			
, Mai	and 2 st ealth and m 27 is n	0	19a. Informant's Name/Relationship Michael Levine/			203 C	edarı	nere	Circle	Owings M	ills,	MD 211	17
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or iteme 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ODGs.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe			Place of Dispo cemetery, crem g Davi	d Men	noria	1 0-22		Falls	ation - City or To Church	, VA
Bal	importing and in	6 9	21. Signature of Funeral Service Lic	censee		1	2. Name <b>p</b> 170 R	affza lockv	nsky™Gol ille Pil	ldberg Me ke Rockvi	emori 111e,	al Garde MD 2085	ens 52
ı	Physician /Medical	3	23a. Part1. Enter the disease, or conshock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a. Non Si	nall	Cell L				c or respiratory a	rest,		Approximate Interval Between Onset and Death
	Examiner	<u>.</u>	Sequentially list conditions,	Due to (or a									
	ecuted and -transit	Examiner	d any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c									
8760,	icate be executed physician and s the burial-transit	cal		Due to (or a	s a conseq	dence of):							
.O. Box 68	The law requires that the death certificat tie has been signed by the attending phy age 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcom 1∐Live birth 4∐Pregnant a 9∐Unknown	2 Feta	Ideath 3□	Ectopic p Other (sp				23	3d. Date of delive Month	ry Day Year
<u> </u>	w requires that been signed b should be deta	þ	Part II. Other significant conditions Chronic Obstruc				, ,	ause give	n in Part I.		obacco us		e cause of death? ably 4 ⊟Unknown
Hecords,		Completed										24b. Were autop prior to con death? 1 \(\sum \text{Yes}\)	osy findings available apletion of cause of
Vital	Physician: The this certificate har al director, page	Be	25. Was case referred to medical examiner?	Hospital:				l Otto		ath Check only o	ne)		
	Phys rthis raldir	. To	1 ☐ Yes 2 🖾 No  27. Manner of Death	1 ☐ Inpat		ER/Outpatien 28b. Time of			4 🗀 Nursing i	lome 5X Resid			)
<u></u>	Attending ir death. ector: After by the fune	atlor	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, D	ay Year)	Injury	м	28c. Injury Work′ 1 □ Y	es 2 □No	233. 233.1231	.017,	00001100	
Division of	Hospital or Attent     A hours after death     Funeral Director: etely filled in by the	Certification:	3 Suicide 6 Could not determine	28e. Place of in	njury - At ho tc. (Specif	ome, farm, stre	eet, factor	y, office		28f. Location (S City or Tow		Number or Rurai	Route Number,
	To the Hospital or Attending Phys within 24 hours attendeath. To the Funeral Director: After this completely filled in by the funeral di	edical (	29a. Certifying (Check only one)	Physician: To the bes aminer: On the basis and manner s	of examina	wledge, death tion and/or inv	occurred restigation	at the time	e, date and place nion, death occ	e, and due to the durred at the time, d	cause(s) a date and p	and manner as sta place, and due to	ated. the cause(s)
	To the within 2 To the complet	Ň	29b. Signature and title of certifier	0.			290	c. License	number			signed (Month, L	
	12		30. Name and address of person wh	io completed cause of	death Item	1 23a) (Type. I	Print)	FOC	-285	*	Herci	12121	2006 024/LAND 208/J
45			JAMES A. BRO	OM UW.	970	A ME	DICA	st (	VIER	RIUS E	CKV	ILE MA	PYLAND
	Sta Registr		31. Date filed (Month, Day, Year) AUG 3 1	2006 32 Regist	rar's Signa	ture	Well !			)		)	20850

			1 - For State Registrar	te of Maryland		nent of He cate of D		Mental Hyg	iene _{9g. No.} 2006	29456
	Physici /Medi		1. Decedent's Name (First, Middle, Last) SELMA MAE	LUM	M			2. Date of Deat Month		3. Time of Death p
	Examir		4a. Facility Name (If not institution, give street ar Washington Coun		al	Hagers		th	4c. County of Deat	h
	Funeral Director		5. Social Security Number 6. Sex 1 M 25 Usual Residence of Decedent	7. Age (In yrs. last		Inder 1 Year oths Days	Hours Min		Year) Co	hplace (State or Foreign untry) Ohio
	72 hours after death with the Maryland naturel; or items 23a or 28a-1 show dical Examinar cass be intiffied at	ector	10a. State 10b. County  Maryland Washing  10e. Street and Number		Town or Location	town				10d. Inside City Limits 1 XYes 2 ☐ No
	ath with	Funeral Director	1304 Pennsylvania			f. Zip Code 2174			U.S.A	,
2-0036	ours after de rel', or Item Executiners	by	1 Never Married 2 Married 1 If Ye	Decedent Ever in U.S. ed Forces? Yes 2 ZNo es, Give r or Dates:			panic Origin? (S , Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Amel Black, White Specify: W	
21215-0	within ane. then	Completed	15. Decedent's Education (Specify only highest grade comple Elementary/Secondary (0-12) Colle 12	eted) ege (1-4or 5+)		Usual Occupated work done du OT use retired)	ion ring most of wa	rking	0wn Hor	·
Maryland 2	ould be filed Mental Hygi erked other atic event, ii	To Be C	17. Father's Name (First, Middle, Last) Edward	Cha	ffin			me (First, Middle, M	faiden Sumame)	Goff
	nd 2 shalth and 27 le m		19a. Informant's Name/Relationship (Type, Print Charles E. Lumm		19b. Mailing Add		nd Number or R	ural Route Number,	City or Town, State, Z	
altimore,	Pages 1 and ment of Healt ent: If item 2: ury or other?		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	from State 20b. Place	e of Disposition etery, crematory View Cer	(Name of or other place)	}	Date 2	narpsburg,	Town, State
Balt	permit. Page Department Importent: If eny Injury of		21. Signature of Funeral Service Licensee  R. Roel Bru	ader	40 1	ast An	cletam :	otreet. Ha	Home, Inc.	Md. 21740
	Physician /Medical		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	that caysed the death. (con such line.	Do not enter the	mode of dying,	such as cardia	c or respiratory arre	st,	Approximate Interval Between In I nd eath
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying	HC R ue to (or as a consequen	reles	fail	ire	,	- (	o days
8/60,	icate be executed physician and s the burial-transit	dical Examin	Cause (Disease or injury that initiated events c.	e to (or as a consequent	noe of);	ne	ction	e.	A CA	days
O. Box 68	death certifi e attending id for use as	Physician/Medic	in the past 12 months?	s, outcome of pregnancy Live birth 2 ☐ Fetal de Pregnant at time of death Unknown	ath 3 Ectop	pic pregnancy or (specify)			23d. Date of delin	very Day Year
ds, P.	8 6 9	۵	Part II. Other significant conditions, contributing	to death but not resultin	ng in the underly	ing cause given	in Part I.		acco use contribute to	the cause of death?
II Kecor	The law ate has b page 2 st	Completed						24a. Was an autopsy perform	ed? prior to co	opsy findings available ompletion of cause of
VItal	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 Ves. 2 Feb. 2			Other		ath Check only one	1	
	ding After fune	-	27. Manner eath 28a. [		Outpatient 3 b. Time of Injury	28c. Injury a Work?	4   Nursing F	lome 5 Resider 28d. Describe how	nce 6 Other (Special vinjury occurred	<i>(y)</i>
	F 8 F F	Certification;	3 Suicide 6 Could not be determined 28e. F	Place of Injury - At home building, etc. (Specify)	, farm, street, fa	ctory, office		28f. Location (Stre City or Town,	eet and Number or Rui State)	al Route Number,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edicai	29a. Certifier (Crieck only one) 1 7 Certifying Physician: T 2 Medical Examiner: On and	o the best of my knowled the basis of examination manner stated.	dge, death occu and/or investiga	rred at the time, ition, in my opin	date and place	, and due to the car irred at the time, dat	use(s) and manner as stee and place, and due t	stated. to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier  AMVS/ Chav, M	D		29c. License r 1) 3665	number	5	d. Date signed (Month,	Day, Year) 2006
3H	-3		30. Name and address of person who completed	cause of death (Item 23:	(Type, Print)	St	140	md 2	1740	
	Sta Registra	_	31. Date filed (Month, Day, Year) 5 2006	32. Registrar's Signature	Locar	and the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of th		· · · ·		

			For State Registrar	State of Ma	aryland / Depa <i>Cer</i>	irtment of I	Health and <i>Death</i>	Mental Hyg	iene 2 0 0	6 29457
	* * 3		Decedent's Name (First, Middle,	Last)				2. Date of Deati	h	3. Time of Death
	Physici /Medio		Daniel	Carr	Main,	Sr.		August	26 200	
1	Examir		4a. Facility Name (If not institution,	give street and number)		4b. City, Town,	or Location of Dea	ath	4c. County of E	
			103 Huse Drive			Anna	apolis		Anne A	rundel
ľ	Funeral Director		577-42-5021	.Sex 7.Ag 1[X]M 2□ F	e (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days			^{Year)} 1916 F	Birthplace (State or Foreign Country) 1orida
	pug *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	nation				101 1-11-01-11-1
	•ho	ō		\						10d. Inside City Limits 1 ☐ Yes 2 No
	the N	Director	10e. Street and Number	Arundel	Annapo1					
	with		103 Huse Drive			10f. Zip Code 214	.02	T.	ng. Citizen of What	•
	leath	era	10.5 Huse DIIVe	12. Was Decedent	Ever in U.S. 13 V	1		Spacific Vac or No.	USA	merican Indian.
Maryland 21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23s or 28s-1 show other traumatic event, the Madical Examiner must be notilized at	by Funeral	1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	Amed Forces?	No 1	Yes, specify Cub		Specify Yes or No- irto Rican, etc.)		white
ğ	2 hou		15. Decedent's	Education	16a. Deced	ent's Usual Occup		1	6b. Kind of Busine	ess/Industry
215	hin 7 Med	Completed	(Specify only highest of Elementary/Secondary (0-12)	grade completed)  College (1-4or 5	life. [	kind of work done OO NOT use retire	during most of word)	orking		,
21	giene Th	, m	20.11511121772000172177 (0 12)	4	Accoun	tant			U.S. Gov	ernment
nd	al Hy al Hy d oth	Be (	17. Father's Name (First, Middle, La	•			18. Mother's Na	ame (First, Middle, M	faiden Sumame)	
yla	Ment Ment arke	2	Daniel Carr Main	1			Edith N	laxson		
<u>a</u>	and and is m		19a. Informant's Name/Relationship					Rural Route Number,		e, Zip Code)
	and lealth m 27 her ti		Blanche C. Main	(Wife)			e, Annar	oolis, MD		
altimore,	ges 1 t of t # ite or ot		20a. Method of Disposition 1 X Burial 2 □ Cremation 3	Removal from State	20b. Place of Dispos cemetery, crem	sition (Name of latory or other pla	ce)	Date 2	loc. Location - City	or Town, State
tim	t. Pa ntmen rtant: njury		4 □ Domation 5 □ Other (Spe		Maryland				Crownsvi	11e, MD
Bal	permit. Pages I Department of H important: if its eny injury or ot once.		21. Signature of Funeral Seylice Lic	ensee	22.	Hardesty 12 Ridge	ss of Facility Funeral 1y Avenu	l Home, P. ie, Annapo	A. lis, MD	21401
П			23a. art1. Enter the dise lise, or co shock, or hear failure. List on	mplications that caused by one cause on each lin	the death. Do not ente	r the mode of dyli	ng, such as cardia	ac or respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (rinal di ease or conditi n resulting in death)	ine	lactate	i C	ance	1		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	- (	ance			
- 123	LXUITITIE		Sequentially list conditions,	b	vs rul	/	once			
	ed isit	Examiner	if any, feating to infine diate cause. Enter Underlying Cause (Disease or injury	Due to (or as	а сонвыдивнов ођ.					1
	and and Il-trar	xan	that initiated events resulting in death) Last	c. Due to (or as:	a consequence of);					-
8760,	icate be executed physician and the burial-transit	E E								
687	ficate phys s the	edicai		d.						
	seath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy				23d. Date of	daliyanı
Вох	d for	cial	in the past 12 months?	1□Live birth 4□Pregnant at		Ectopic pregnancy Other (specify)	y		Month	Day Year
o.	that the death ed by the atte detached for	hys	9 Unknown	9□ Unknown						
Vital Records, P.	9 P	þ	Part II. Other significant conditions	contributing to death bu	ut not resulting in the un	derlying cause giv	en in Part I.			e to the cause of death?  Probably 4 □Unknown
Ö	w requir been s should	Completed						24a. Was an	24h Wara	autoney findings available
Re	he lav e has age 2	ш						autopsy	prior	autopsy findings available to completion of cause of ?
ta		0	25. Was case referred to medical				Of Diago of Do	1 Yes 2		es 2□ No
		ToB	examiner?	Hospital:	nt 2 ER/Outpatient	3□ DOA Oth		hath (Check only one Home 5 Resider		
0	g Physical dispersal di		27. Manner of Death	28a. Date of Injur (Month, Day	y 28b. Time of	28c. Injur		28d. Describe hov		респу)
<u>.</u>	Attending in death.	atio	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigat		Year) Injury		Yes 2 □ No			
Division of	al or Atta	Certification:	3 Suicide 6 Could not determine		iry - At home, farm, stre . (Specify)	et, factory, office		28f. Location (Stre City or Town,	eet and Number or State)	Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical (	29a. Certifier 1 Certifying I (Check only one)	Physician: To the best caminer: On the basis of and manner sta	examination and/or invi	occurred at the tirestigation, in my o	ne, date and place pinion, death occ	e, and due to the cau urred at the time, dat	use(s) and manner te and place, and c	as stated. lue to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier	1/1		29c. Licens	e number	290	d. Date signed (Mo	onth, Day, Year)
			Curtis	Han	in, und	1	1533	506	8/25	100
			30. Name and address of person wh	o completed cause of de	eath (Item 23a) (Type, F	Print)			- ( 3/	mD 21 80
	10-11		Curtis Harr	18, 119	900 Bost	sate k	ed ste	300 An	napoles	MD 2180
	Sta Registra		31. Date filed (Month, Day, Year)	2006 32 Registra	r's Signature	and the same				

			1- State of Maryland / Department of Health and Certificate of Death	d Mental I		2006	29458
	e		Decedent's Name (First, Middle, Last)	2. Date o	Death		3. Time of Death
	Physici /Medio	al	Wiley Edison Mabe	Septem		Year	6 729 M
1	Examir	er	4a. Facility Name (If not institution, give street and number)  4b. City, Jown, or Location of De  LORIEN ORIGINAL SIDE  Above the control of De  LORIEN ORIGINAL SIDE  4b. City, Jown, or Location of De	eath `	40	County of Dea	e )
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H		Birth Day, Year)	9. Bir	thplace (State or Foreign
	Director		198-14-9500 11 M 2□ F 88 Yrs. Months Days Hours M.  Usual Residence of Decedent	02/2	7/1918	8 No	rth Carolina
	show		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	8a-f s	Director	MD Harford Havre de Grace				1 ☐ Yes 2 X No
	with the	Dire	10e. Street and Number 10f. Zip Code			tizen of What Co	ountry?
	death ms 23	Funeral	3678 Old Level Road  12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	(Specify Yes o	US,	14. Race - Ame	erican Indian,
36	s after or Ite		Armed Forces?  1 □ Never Married 2 ☑ Married  1 □ Yes, Sive  1 □ Yes 2 ☑ No Specify:	ierto Rican, etc.	)	Black, Whi	
Ö	within 72 hours after death with the Maryland ene. then "naturel", or Items 23a or 28a-f show he Mcdical Examiner in ust be multified at	ed by	3 Wildowed 4 Divorced Year or Dates: WWTT  15. Decedent's Education 16a. Decedent's Usual Occupation		16b K	(ind of Business	rite
215	thin 72 e. en na Media	Completed	(Specify only highest grade completed)  (Give kind of work done during most of will be DO NOT use retired)  (Give kind of work done during most of will be DO NOT use retired)	working	100.10	and or business	midustry
7	filed wi Hygien other th		5th Maintenance Mechanic			oe Compo	any
Maryland 21215-0036	ld be fi ental h ked ot c ever	o Be	Wiley Mabe  Flora	Name (First, Mic Dhau+s	ldle, Maiden	Sumame)	
ary	2 should and Men Is marke aumatic	F	19a. Informant's Name/Relationship ( <i>Type, Print</i> )  19b. Mailing Address ( <i>Street and Number or a</i>		mber, City o	or Town, State, .	Zip Code)
	and 2 lealth m 27 I		Clyde V. Mabe- Wife 3678 Old Level Rd.,	Havre d	e Grad	ce, MD :	21078
nor	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition  1X Burial 2 ☐ Cremation 3 ☐ Removal from State	Date		ocation - City or	
Baltimore,	그 문 환 글	- 9	*4 □Donation 5 □Other (Specify) Rock Run Cemetery 109/ 21. Signature of Funeral Service Liggingse 22. Name and Address of Facility.	14/06	Havi	re de G	iace, MD
ä	Depar Impo		21. Signature of Juneral Service Literase Witchell-Smith Full 123 S. Washington	neral H St., H	ome, l avre d	P.A. de Grace	2. MD 21078
			23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardishock, or heart failure. List only one cause on each line.	liac or respirato	y arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a				2 weeks
	Examiner		Due to (in ras a consequence of):				119001
7	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				9.000
	xecute and	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):				
8760,	icate be executed physician and s the burial-transit	dicai E	d				
Ö	artifica ing ph e as th	Medi	IF FEMALE:				
Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?			23d. Date of del Month	ivery Day Year
О	that the de ed by the a detached t	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown 5 ☐ Other (specify)				
	res tha igned be del	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				the cause of death?
Records,	w require been si should	eted	anemia	-	<del></del>	DXNo 3□Pr	obably 4 Unknown
	he law e has age 2 s	Completed			itopsy orformed?	prior to death?	topsy findings available completion of cause of
Vital		Be C	25. Was case referred to medical examiner? 26. Place of Di	1 ☐ Ye eath (Check on		1 □ Yes	2 No
o t <	Physic this ce al dire	P	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing			6 □Other (Spec	pify)
Division of	iding Phy th. : After this funeral d	Certification:	27. Manner of Death  1 Denating 28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?  2 Accident investigation  28b. Time of Injury Work?  1 Yes 2 No	28d. Descri	oe how <del>i</del> njur	y occurred	
N S	I or Attendi after death. Director: A I in by the fu	tifica	3   Suicide 6   Could not be determined 4   Homicide determined building, etc. (Specify)	28f. Locatio	n (Street an Town, State	d Number or Ru	ral Route Number,
	oitel or A urs after orel Directiled in by					,	
	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certification completely filled in by the funeral director.	Medical	29a. Certifier  (Check only one)  1 ★ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date occurred at the time, date of the basis of examination and/or investigation, in my opinion, death occurred at the time, date of the basis of examination and/or investigation, in my opinion, death occurred at the time, date of the basis of examination and of the basis of examination and occurred at the time, date of the basis of examination and occurred at the time, date of the basis of examination and occurred at the time, date of the basis of examination and occurred at the time, date of the basis of examination and occurred at the time, date of the basis of examination and occurred at the time, date of the basis of examination and occurred at the basis of examination and occurred at the time, date of the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occur	ce, and due to t curred at the tin	he cause(s) ie, date and	and manner as I place, and due	stated. to the cause(s)
	To the within To the Comple	Me	29b. Signature and title of certifier 29c. License number		29d. Dat	e signed (Monti	n, Day, Year)
1	/x\		D27975		9/1	106	
	15		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  NEW MY 6/5 New Man 6/5 New Man A A.	. 1 D	1-10	21111	
• 12	Sta	e	31. Date filed (Month, Day, Year) 32. Registrar's Signature	ed spir	JUN /	. 0019	
	Registr	ar	SEP 1 5 2006 Reserve B. Aposti				

			1 = For State Registrar	Please		nt in Black II aryland / Dep <i>Ce</i>		Health and M	lental Hy			29459
	Physici /Medio			G. MOON	íAU UAU				2. Date of De Sept.		2006	3. Time of Death 5: 04 PM
	Examir Funeral Director	ner	Lions M. 5. Social Security N 234-42-9	anor Nurs		ne (In yrs. last birthday 82 Yrs.	Cur		8. Date of Bi (Month, D. Jan. 9	rth ay, Year)	Cou	
1	f show	tor	Usual Residence of 10a. State	10b. County  Miner	- 21	10c. City, Town or L						10d. Inside City Limits 1X Yes 2 □ No
4	3a or 28a at be notif	al Director	10e. Street and Nun	mber	ne, Apt.		yser 10f. Zip Code 267	726		10g. Citize	en of What Cou USA	ntry?
020	of fairs associated by the first state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of th	by Funeral	11. Marital Status	ed 2 Married	12. Was Decedent Armed Forces? 1 □ Yes 2 X If Yes, Give Year or Dates:	Ever in U.S. 13	. Was Decedent of	Hispanic Origin? (Spo pan, Mexican, Puerto	ecify Yes or No Rican, etc.)		Race - Ameri Black, White, Specify:	etc.
0-6171	aith and Menta Hygiene 27 Is marked other than "natural", or traumatic evant, I'm Medical Era	Completed	(Spec	15. Decedent's Edify only highest grandary (0-12)		(Giv 5+)	DO NOT use retire	during most of work	ing		of Business/Ir	ndustry
מוומ	ental Hygie ked other ic evant, II	To Be Co	17. Father's Name (			Co	ок	18. Mother's Name	e (First, Middle	, Maiden Si	umame)	School
, Ividity	aith and M n 27 Is mar er traumati		19a. Informant's Na	ame/Relationship (	Type, Print) Daughter		ling Address (Stree	t and Number or Rura		er, City or T	Town, State, Ziji	o Code)
	tment or tant: If			☐ Cremation 3 ☐ 5 ☐ Other (Specifi		Potomac M	ematory or other pla	Sept	. 12 06	20c. Loca	ser, WV	own, State
ם פ	Impo any ir once	I	23a. Part1. Enter th	red for com	Julia ofications I hat caused	the death. Do not er	85 S. Ma	in Street	nith Fu Keyse or respiratory a	r, WV		Approximate
	hysician /Medical xaminer		Immediate Cause ( disease or condition resulting in death)	Final	a. Sepsi	ne.	rome.					Interval Between Onset and Death
icate he executed		dical Examiner	Sequentially list cor if any, feating to micause. Enter Under Cause (Disease or that initiated events resulting in death) L	rlying injury	с.	a consequence of):						
The law requires that the death certificate	ned by the attending physical detached for use as the b	Physician/Medi	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		230	d. Date of delive Month	əry Day Yəar
Tuires that	been signed be should be det	by			ontributing to death b	ut not resulting in the i		ven in Part I.			contribute to the	ne cause of death?
The law co	cate has bee page 2 sho	Completed							24a. Was autor perfo 1 🗆 Yes		prior to co death?	psy findings available mpletion of cause of
VILLE	this certificate	o Be	25. Was case referrexaminer?	,	Hospital:	int 2 ☐ ER/Outpatie	ont 3□ DOA Ott	26. Place of Death her: Nursing Hor			7011 (0	
To the Hospital or Attanding Physician	fter	atlon: T	27. Manner of Death 1 Natural 2 Accident	5 ☐ Pending investigation	28a. Date of Inju (Month, Day	ry 28b. Time o	of 28c. Inju		28d. Describe			<i>y</i> )
oital or Aff	withir, 24 hours after death.  To the Funeral Director: A completely filled in by the fu	I Certification	3 Suicide 4 Homicide	6 Could not be determined	building, etc			Ī	City or To	wn, State)		l Route Number,
o the Hos	ithir 24 ho o tha Fun ompletely f	Medical	29a. Certifier (Check only one)  29b. Signature and	2 Medical Exem	vsicien: To the best of liner: On the basis of and manner sta	of my knowledge, dea f examination and/or in ted.	th occurred at the tinvestigation, in my of	opinion, death occurre	ed at the time,	date and pl	ace, and due to	the cause(s)
-	s F 0			nsock.		MD		5325			08, 2	
	3			insock	Shin	eath (Item 23a) (Type 48 Tarn	Terrace	. Frostbu	urg. Mi	0 21	532	
	Sta	te	31. Date filed (Month	n, Day, Year)	32. gistra	ar's Signatura	A TOTAL					

DHMH 17 Rev 1/2001

Registrar

SEP 1 5 2006

			1 - For State Registrar	State of Marylar		artment rtificate				~	200	6 29	461
	Physici		1. Decedent's Name (First, Middle, Last)	ortin	Mide		0, 20		2. Date of De Month Aug. 3	ath		3. Time of I	
1	/Medic Examir		4a. Facility Name (If not institution, give s Shady Grove Adv	treet and number)		4b. City, To	own, or Loc	ation of Dea		4c	County of De	ath	
	Funeral Director			7. Age ( <i>In yr</i> s. 78 78	last birthday) Yrs.	If Under 1 Months (		Under 24 Hrs lours Min		th ly, Year) 27, 1	9. B 928 H	irthplace (State or Country) onduras	_
	e Maryland 8a-f show	ctor	Usual Residence of Decedent           10a. State         10b. County           none         none		ty, Town or Lo <b>Feguci</b>		а, Но	ondur	as			10d. Inside City	•
	th with the	Funeral Director	10e. Street and Number 16th Avenue, 2nd	Street, Ho	use 15	10f. Zip C	ode			-	ndura	•	
9036	within 72 hours after death with the Maryland ene. than 'neturel', or Items 23s or 28s-f show he Madical Examinar must be notified at	d by Funer	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1	i				Specify Yes or No no Rican, etc.) nduran	-	14. Race - Am Black, Wh Specify:	nerican Indian, ite, etc. White	-
Maryland 21215-0036	be filed within 72 hours ital Hygiene. Id other than "naturel", event, the Medical Exa	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+) 4	(Give life. L	lent's Usual ( kind of work DO NOT use	done durin retired)	n g most of wo	orking	16b. K	ind of Busines	s/Industry	
yland	ould be fill Mental Hy arked oth atic eveni	To Be	17. Father's Name (First, Middle, Last) Angel Fortin						a Mider		Sumame)		
, Mar	and 2 should teath and Ment salth and Ment n 27 le marke er traumatic		19a. Informant's Name/Relationship (Type Dolores Lagos D	e Fortin/ Wife				untry ouse#	1514 Te	a ^{city} B	ender igalp	K ^{ip} 1969 Av a, Hondu	enue
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 le marke any injury a giber traumatic ance.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Cer	Place of Dispose Complety, creat Meteri guciga	lov de lpa	er place)		7/06		ocation City of Juciga Hondu		
Bal	Departing Impo		21. Signatur peral Service Licente	Ad-					I FUNER lvd.Sil		SERVI Spri	CE,P.A. ng,Md20	910
-	Physician /Medical Examiner	Examiner	23a. Parl1. Enter the disease, or complice shock, or head failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Multi org  Due to (or as a conseq  Pneumonia  Due to (or as a conseq  Pleural e	gan sy quence of): a quence of): effusi	rstem			ic or respiratory ai	rrest,		Approximate Interval Between 3 days  8 days  2 week	reen eath
.O. Box 68760,	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	Due to (or as a consequence of pregnation of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the co	ancy	Ectopic pregi					23d. Date of de Month	blivery Day Ye	ar ear
ords, P.	w requires that been signed t should be det	۾	Part II. Other significant conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions condit					Part I.		obacco u res 21	_	o the cause of dea	
	The law ate has b page 2 st	Completed									24b. Were a prior to death? 1 ☐ Ye	utopsy findings av completion of cau s 2 No	/ailable use of
Vit.	Physician: T this certificat ral director, pa	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No	ospital: 1 ⊈Inpatient 2 □	ER/Outpatient	3□ DOA	1 04		ath Check only o		6 Dother (Co.	20(64)	
sion of	Afte fune		27. Manner of Death  1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Injury at Work?		28d. Describe h			scily)	
Divi	To the Hospital or Attend within 24 hours after death To the Funeral Director: / completely filled in by the f	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specifical Control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of	y)				City or Tou	m, State	)	ural Route Numbe	97,
	To the Hospital o within 24 hours aff To the Funeral DI completely filled in	Aedical	one)	cien: To the best of my kno er: On the basis of examina and manner stated.	wledge, death ition and/or inv	estigation, in	my opinio	n, death occi	urred at the time, o	date and	place, and du	e to the cause(s)	
	2 3 2 5	Σ		IF P. KURU		up .		187	4	AUG.		0,200	56
			30. Name and address of person who cor AjitP Kuruvill	a MD 11125	n 23a) (Type, F Rockv	rint) rille	Pike	e #20	5 Rockv	il l e	∍,Md 2	0852	
7	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 1 20	32. Registrar's Signa	ture	ale							

	-	For State Registrar  1. Decedent's Name (First, Midde		of Marylar		artment of H		2. Date of Dea	eg. No.ZL	006	2946 I
Physicia		Lily Ann Masc						Sept.	3 2	2006	9:34 P M
/Medic Examin	100	4a. Facility Name (If not institution 32 Manor Driv	n, give street and	number)		4b. Cily, Town, or Hagers	Location of Death			ty of Death hingt(	on
Funeral Director		5. Social Security Number 216-30-3447	6. Sex 1 ☐ M 2 🔀		. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 04/27/1	, Year)	9. Birthr Cour	place (State or Foreign ntry) MD
A T		Usual Residence of Decedent  10a. State 10b. Count	/	10c. C	ity, Town or Lo	ocation					10d. Inside City Limits
art ehc	tor	MD Washi	ngton	Ha	gersto	wn					1X Yes 2 □ No
258 Or zo	Funeral Director	10e. Street and Number 32 Manor Driv	re #203			10f. Zip Code 21740			I0g. Citizen o	S	
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dical	Completed	15. Decede (Specify only high	nt's Education est grade comple	ed)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of worl	king	16b. Kind of	Business/In	ndustry
TR MS	duc	Elementary/Secondary (0-12)	Colle	ge (1-4or 5+)		nk Teller				Bankiı	ng
T.	BeC	17. Father's Name (First, Middle	, Last)				18. Mother's Nam			ame)	
	To B	Charles J. Mo	ore					. Harmon			
r other treum		19a. Informant's Name/Relation Carolyn Beck		er	32 M	ng Address (Street anor Driv	e #203, I	Hagersto	wn, MD	21740	0
or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 Removal f	rom State	cemetery, cre	osition (Name of matory or other place	1 (	Date	20c. Location		
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ian		shock, or heart failure. Li Immediate Cause (Final disease or condition	st only one cause	1	1.0	C					Onset and Death
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	/ Ph	Part II. Other significant condi	tions contributing	to death but not re	esulting in the	underlying cause giv	ven in Part I.	23e. Did to	obacco use co	ontribute to	the cause of death?
								101	res 2□No	3 Pro	bably 4 □Unknown
	Completed							24a. Was autop perfo		prior to co death?	opsy findings available ompletion of cause of
		25. Was case referred to medi	and .				26 Blace of Do	1 Yes		1 🗌 Yes	2□ No
	To Be	examiner?	Hospital:	1 ☐ Inpatient 2	☐ ER/Outpatie	ent 3 DOA Ott		tome 5 PResid		Other (Spec	ufy)
	tion: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pen	28a. I ding stigation	Date of Injury (Month, Day Year)		of 28c. Inju	ry at rk? ]Yes 2 □ No	28d. Describe	now injury occ	curred	
	Certification:	3 ☐ Suicide 6 ☐ Cou	mined 200.	Ptace of Injury - At building, etc. (Spe	home, farm, s	treet, factory, office		28f. Location (S City or Tox		mber or Ru	ral Route Number,
	Medical (	29a. Certifier 1 Certification Check only 2 Medicone)	at Examiner: On	o the best of my k the basis of exami manner stated.	nowledge, dea ination and/or i	ith occurred at the ti nvestigation, in my	ime, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and date and plac	manner as ce, and due	stated. to the cause(s)
completely litted in by ine tangen anector. Page	Me	29b. Signature and title of cert	fier				se number		29d. Date sig		
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-		30. Name and address of pers	MCCor		tem 23a) (Type	Print) Nedre	1 Com	pus B	2900	hour	MO.
	ate	31. Date filed (Month, Day, Ye	ar)	32. Registrar's Sig	gnature	,					
gist	* 4	SEP 0	6 2006	Deriem	1. A.	red -					
17 Rev 1/2	2001				ORIG	INAL					

			1 - For State Registrar	State of Maryla	nd / Depa <i>Cei</i>	artment of	f Health ai of Death	nd Mental Hy	giene 200	6 29462
	Physici /Medic		Decedent's Name (First, Middle, Last Richard Joseph		У			2. Date of De Month Augu	1 Day Ye	3. Time of Death
	Examir		4a. Facility Name (If not institution, give 100 Walbeck Lane			North	n, or Location of 1 East		4c. County of C	1
	Funeral Director		5. Social Security Number 6. Se 195–36–1516  Usual Residence of Decedent	x 7. Age (In yrs	7 Yrs.	If Under 1 Ye Months Da		Min. B. Date of Bir (Month, Danuary	av. Year)	Birthplace (State or Foreign Country) New Jersey
	Maryland	tor	10a. State 10b. County Maryland Cecil		ity, Town or Lo					10d. Inside City Limits 1 ☐ Yes 🏋 No
	3s or 28s	i Direc	10e. Street and Number 100 Walbeck Lane			10f. Zip Cod			10g. Citizen of What	•
036	be filed within 72 hours after deeth with the Maryland tal Hygiene. d other than "neturel", or Iteme 23e or 28e-f ehow event, I'm Medical Examinar must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 Narried  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of Yes, specify C	Cuban, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)		mencan Indian, /hite, etc. White
Maryland 21215-0036	filed within 72 ho Hygiene. ther then "netur int, in Medice.	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0·12)		(Give	DO NOT use re	ne durina most d	of working	16b. Kind of Busine	ess/Industry
land	2 should be filed volume and Mental Hygie	To Be C	17. Father's Name (First, Middle, Last) John McSorley					s Name (First, Middle icia Sheeh		
	5 = 2 t		19a. Informant's Name/Relationship (7) Shirley E. Stokes	ype, Print)				or Rural Route Numb orth East,		
Baltimore,	Pages 1 er nent of Hea ant: If Item ary or othe		20a. Method of Disposition 1 □ Burial 2 🖾 Cremation 3 □ f 4 □ Donation 5 □ Other (Specify,	Removal from State	cemetery, crer	sition (Name of matory or other) Cremat	place) A11	gust 31, 2006	20c. Location - City Newark,	
Balt	permit. Pages Department of I Important: If Ite any Injury or of		21. Signature of Funeral Service Licens	will			dress of Facility	Crouch F North Ea	uneral Houst, MD 2	ne 1901
8760,	Cate be executed hysicien and hysicien and hysicien and the burial-transit	dicai Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect.  Due to (or as a consect.  Due to (or as a consect.  Due to (or as a consect.)	quence of):	4.1	- 0	hypoph		Approximate Interval Between Onset and Death Twowalls
O. Box 6	ne death certifi the attending I shed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	aldeath 3□	Ectopic pregna Other (specify			23d. Date of Month	delivery Day Year
Δ.	quires thet tl in signed by uld be detac	þ	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	nderlying cause	given in Part I.	23e. Did t	*	e to the cause of death?  Probably 4 □Unknown
of Vital Records,	The ete h page	Completed						24a. Was auto pento 1 □ Yes		autopsy findings available to completion of cause of 7
Vita	Physiclan: this certific al director,	Be	25. Was case referred to medical examiner?	Hospital:			Othor	of Death   Check only o	2.72	
on of	fing After funer	tion; To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Inpatient 2 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Ir	4 ☐ Nurs		dence 6 □ Other (S how injury occurred	Specify)
Division	9 8 5 E	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of Injury - At h building, etc. (Spec	nome, farm, str ify)	eet, factory, offi	се	28f. Location (: City or To	Street and Number or wn, State)	Rural Route Number,
	To the Hospital within 24 hours e To the Funeral I completely filled	Medical (	29a. Certifier (Check only one)  1  Certifying Phy 2  Medical Exam	sicien: To the best of my kn iner: On the basis of examin and manner stated.	owledge, deatl ation and/or in	n occurred at the vestigation, in m	e time, date and ny opinion, death	place, and due to the occurred at the time,	cause(s) and manner date and place, and	as stated. due to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	, MD		29c. Lic	ense number	14	August	
•			30. Name and address of person who c	ompleted cause of death (Ite	m 23a) (Type,	Print)	17 )/	. / _	J1 - 744/	31,2006
	15 Sta	10	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ons /	tospice	, E	/KTon,	MP	
	Registr		SEP 1 2006	Mount &	Sperte	1				

			State of Maryland / Dep	artment of Health and M rtificate of Death		2006	29463
	Dhusisi		Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year	3. Time of Death
	Physici /Medic	cal	Jean Joseph Occio  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	August :	27,2006   lc. County of Death	11:20a ^M
	Examin	ier	Montgomery General Hospital	Olney		Montgome	
Ī	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 092-70-7306 180 M 2 F 80 Yrs.	If Under 1 Year   If Under 24 Hrs.     Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Yea Nov. 11.	9. Birthpla Countr 1925 Hait	ce (State or Foreign y) _i
	D >		Usual Residence of Decedent	peation	NO VIII		d. Inside City Limits
	Marylan f show	lor	Md Montgomery Olney				1 □ Yes 2 No
	with the 3a or 28a It be notifi	Funeral Director	10e. Street and Number 18205 Bowie Mill Road	10f. Zip Code 20832	10g. (	Citizen of What Countr	y?
136	within 72 hours after deeth with the Maryland liene. Then "natural", or items 23s or 28s-( show Itte Macical Examiner must be multified at	by Funera	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I 1 ☐ Yes 2 No Specify:	cify Yes or No- Rican, etc.)	14. Race - America Black, White, et Specify: Bla	c.
Baltimore, Maryland 21215-0036	nin 72 hou n natura Nedical E	Completed	(Specify only highest grade completed) (Give	ident's Usual Occupation kind of work done during most of workii DO NOT use retired)	ng	Kind of Business/Indu	
N	P S S		4 Ci-	vil Engineer	(First. Middle, Maid	Construct	tion
ana	id be fil ental H ked ott ic even	To Be	17. Father's Name ( <i>First, Middl</i> e, <i>Last)</i> Joseph Occident		nce Benn	- ,	
ary	2 shoul and Me ie mark sumati	F	19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Rura			
ē, ≥	1 and Health em 27		20a Method of Disposition 20b. Place of Disp			Location - City or Tow	
Ē	Page nert of int: if if		1 (\$\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\exititt{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\	f Heaven Cem. 9	/02/06 S	ilver Sp	ring,Md
Bait	permit. Pages 1 and 2 should be fill Department of Healin and Mental H important: if item 27 ie marked out any injury pr other traumatic even once.		21. Signatur of Funeral Service vice ree	ATTIP MERTNÄLDI 241 Columbia Bl	FUNERAL vd.Silve	SERVICE r Spring	P.A. ,Md20910
İ	-		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.		r respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	aucer			
ı	Examiner		Sequentially list conditions, b.				
	d d anslt	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
8760,	cate be executed physicien and the burial-transit		resulting in death) Last  Due to (or as a consequence of):				
284	ntificate	Aedical	IS SCHALE.				
P.O. Box	The law requires that the death certificate has been signed by the attending plages 2 should be detached for use as it	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of deliver Month	y Day Year
ds, P.	quires that i n signed by uld be deta	Ď	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	. /	ouse contribute to the	e cause of death?
Vital Records,	The law requir sete has been si page 2 should I	Completed			24a. Was an autopsy performed	? prior to com	sy findings available pletion of cause of
Vital	ysicien: Th is certificete director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death			
ō	9 Phys er this eral dir	n; To	27. Manner of Death 28a. Date of Injury 28b. Time		me 5 Residence 28d. Describe how in		
Division of	or Attending Physicien: after death. Director: After this certification by the funeral director.	Certification;	1	M 1 Yes 2 No	28f. Location (Street City or Town, St	and Number or Rural ate)	Route Number,
ā	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	edical Cer	29a. Certifier  (Check only 2   Medical Exeminer: On the basis of examination and/or i	th occurred at the time, date and place, nvestigation, in my opinion, death occurr	and due to the cause	e(s) and manner as sta and place, and due to	ited. the cause(s)
	within 2-	Med	one) and manner stated.  29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, D	Pay, Year)
)	3(1)		Ville The	D 005941	9 1	Lugust	29,2006
	~ 0		30. Name and address of person who completed cause of death (Item 23a) (Type DA, RAKHUA VIV	Print) Vladimir Ral	chmanin A/CP	MD) ~ ()	29, 2006 Uney 200
	St Regist	ate trar	31. Date filed (Month, Day, Year)  SEP 0 1 2006  32. Registrar's Signature	parti	/		"MO

		1	For State Registrar	State of Marylai		artment of He		Лental Hyg в	jiene _{eg. No.} 2	006	29464
	36		1. Decedent's Name (First, Middle, Last)				-	2. Date of Dea Month		Year	3. Time of Death
Phys . /Me	siciar edica	-	WILLIAM COURSEY	PARKS, JR.				Sept.	3, 200	)6	6 <b>:</b> 56 a ^м
Exar	mine	r '	4a. Facility Name (If not institution, give s			4b. City, Town, or I				nty of Death	
			Coastal Hospice at 5. Social Security Number 6. Sex		. last birthday)	Salisbur	Y If Under 24 Hrs.	8. Date of Birth		mico	place (State or Foreign
Funer Direct				Tu	74 Yrs.	Months Days	Hours Min.	(Month, Day 8/14/1	Year)	Mary	ntry)
TO .		-	Usual Residence of Decedent					9/11/			
arylar ehow	١,		10a. State 10b. County		ity, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 No
he Mi		200	MD Worceste  10e. Street and Number	er G	irdlet	10f. Zip Code			Oc. Citizen	of What Cou	
with 1	2	5	5925 Taylor Landir	og Poad		21829	)		US		indy:
death with the Maryland ms 23a or 28a-f ehow		runeral Director		12. Was Decedent Ever in t	J.S. 13.	Was Decedent of His If Yes, specify Cuban		pecify Yes or No-	14. F	Race - Ameri	
after or Its	ı	2	1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 ☐ Yes 2 25No If Yes, Give		ir Yes, specify Cuban 1 □ Yes 2 🛣 No	Specify:	) Rican, etc.)		Black, White,	
Nours af		a by	3 Widowed 4 Divorced	Year or Dates:						WILL	
72 h		Completed	15. Decedent's Edu (Specify only highest grade	cation e <i>completed)</i>	(Give	dent's Usual Occupat kind of work done du DO NOT use retired)	uring most of worl	king	16b. Kind of	f Business/In	ndustry
withiir energy than		E	Elementary/Secondary (0-12)	Colfege (1-4or 5+)	Water				Seafo	ood	
filed Hyginether		200	17. Father's Name (First, Middle, Last)		11.0-0-0-		18. Mother's Nam	e (First, Middle,	Maiden Surr	name)	
VICTOR  uld be fil  Mental H  rrked oth		0	William Coursey Pa	arks, Sr.			Sarah E	lizabeth	Heath	ם	
Mary d 2 sho h and ? 7 is ma		1	19a. Informant's Name/Relationship (Type Elizabeth Parks (V			ng Address (Street ar Box 149,				wn, State, Zij	o Code)
Te, I		ŀ	20a. Method of Disposition		Place of Dispo	osition (Name of		Date		on - City or To	own, State
Pages ent of t: If t			1 🔀 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	temoval from State		matory or other place Baptist Ceme		2006	irdle	tree,	MD
DESILITIONEY, METYIGITIC ZIZIO-0050 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than 'natural', or Items 23a or 28a-1 ehow any injury or other fraumatic event, the Medical Examinat must be multilled an	once.		21. Signature of Funeral Service License		H	2. Name and Address Olloway Fi 03 Linden	of Facility H	ome, P.A	 City.	MD 21	851
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused the dea							Approximate Interval Between
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/Medic	al		resulting in death)	Due to (or as a conse	quence of):		-				
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<b>oU,</b> be executed icien and burial-transit		Xar	that initiated events resulting in death) Last	Due to (or as a conse	equence of):						
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rifical ng physics the as the		Med	IF FEMALE:						1		
Geath certificate attending produce as ti		cian/me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregr 1 Live birth 2 □ Fe	tal death 3	Ectopic pregnancy				Date of deliv Month	ery Day Year
. 0 0 2		nysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	death 5	Other (specify)					
that the ed by detac	č	7 I	Part fl. Other significant conditions con	ntributing to death but not re	sulting in the u	inderlying cause give	n in Part I.	23e. Did to	bacco use c	ontribute to t	the cause of death?
ecords, F.C. law requires that the de as been signed by the 2 should be delached		o D						1 🗆 Y	es 2 🗆 No	3 Prol	bably 4 Unknown
N Tec		Set						24a. Was		b. Were auto	opsy findings available
r a f		Completed						autop perfor 1 Yes	med?	death?	ompletion of cause of 2000 No
VICAL Ician: T certificate ector, pg		D P	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only or			
OT V Physic this ce		0	1 Yes 2 Vie		☐ ER/Outpatie		4   Ivursing n	ome 5 Resid	ence 6 🗆	Other (Speci	fy)
On On ding Ph h. After th funeral			27. Manner of Death  1 ☑Naturaf 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of finitury	Work		28d. Describe h	ow injury oc	curred	
VISION OT VITA Attending Physician: r death. ector: Atter this certific by the funeral director.		cat	Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At	home farm et		'es 2 □No	28f Location (S	treat and No	imber or Rus	al Route Number.
DIVISION al or Attending s efter death. Il Director: Afte		Certification	4 Homicide determined	building, etc. (Spec	cify)	геец, тастогу, оптсе		City or Tow		iniber of Aur	ar noute Number,
DIVISIO  To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A  completely filled in by the fu		edical		sician: To the best of my kr ner: On the basis of examinand manner stated.							
To th within To th	:	Me	29b. Signature and title of certifier			29c, License				ned (Month,	
			1		22		8410			13/0	
ه ۸ ۵	,		30. Name and address of person who co	ompleted cause of death (Ite	em 23a) (Type,	Print)		1:22	W a		( VA )
BA7			31. Date filed (Month, Day, Year)	32 Projetrar's Sing	nature	Print) WWDO()	CT. SA	tus su	ny	ny 2	180/
Reg	Stat istra		SEP 0 5 2	006	N A	mede					

# Please Type or Print in Black Indelible Ink of Maryland / Department of Health and Mental Hy

Robert Taylor Phe	•	•	State	e of Maryla	nd / Depa		Health a		Hygi	ene	2 4	2011
Dhysisian		I- For State Registrar 1. Decedent's Name (F	irst Middle La	est)	Ce	rtificate of	Death		2. [	Reg	. No. 20	06 2146
Physician Medical Examine	w	Robert	Tay1		helps,	Sr.			A	Month logust 30,	2006	0645 hrs
para .		4a Facility Name (if no 11650 Mount \			mber)		4b. City, Town, o	or Location of De	ath		4c. County of D	eath
Funeral	٩	5. Social Security Num			7. Age (In yrs.	last birthday)	If Under 1 Ye	ear If Under 24			(MM/DD/YYYY) 9	. Birthplace (State or
Director		216-30-48	32 1	X м 2 F	72	Yrs	Months Da	ays Hours D	^{Min.} e ce	mber	6,1933 ^F	washington DC
y.	Ī	Usual Residence of De	cedent c. County	•	10c City	, Town or Locat	ion					10d Inside City Limits
id how any		MD	Char	les		t. Vic						1 Yes 2 No
farylan	Director	10e. Street and Number					10f. Zip Code			100	. Citizen of What	Country?
ith the Maryland 23a or 28a-f show		11650 M	t. Vi					0661			USA	
ath wir	Funeral	11. Marital Status  1 Never Married	2 Marrie	Armed Fo				lispanic Origin? an, Mexican, Pue			14. Race - A White, e	merican Indian, 8lack, tc.
after de	2	3 Widowed	4 X Divorce	Yes ed If Yes, Give Yea or Dates:	2 No	1	Yes 2 X	lo specify:			Specify:	White
hours natur	9	15. Decedent's Educa Elementary/Seconda		only highest grad College (1				ation (Give kind fe. DO NOT use		done	16b. Kind of Busin	ess/Industry
336 thin 72 re. than '	Completed	12	ary (0-12)	College (1	1-4 01 3+)	H H	armer				Farmir	n or
215-0036 be filed within 7 ntal Hygiene. ked other than ent, the Medica		17. Father's Name (Fire		•			<u>armor</u>				aiden Surname)	
2121 Muld be f Mental markee	o Re	Taylor J  19a. Informant's Name.	. Phe	lps (Type, Print)		19b. Mailin	Address (Str	Marga eet and Number	ret	E. P	hibbons er, City or Town, S	State, Zip Code)
re, MD 2: 1 and 2 should F Health and M If item 27 is m er traumatic e	-1	Helen Re 20a. Method of Dispos			n/Sist	. 4						
nore, MD 21215-0036  ages 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygtene.  tt: If item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Dispos 1 Burial 2X	ition Cremation 3	Removal fro	20b.	Place of Dispos crematory or of	sition (Name of o her place)	cemetery,	Da	ite	20c. Location - Cit	y or Town, State
timo L. Page tment or rant:		4 Donation 5	Other Speci	fy:	Br							te Hall,MD
Baltimore, permit. Pages I and Department of Heal Important: If item injury or other tra		21. Signature of Funer	Service Lice	ensee	_ M009	45   ²² A					L HOME,	P.A. A.MD 20646
Physician	1	23a. Part I. Enter the d			aused the deat	h. Do not enter t	he mode of dyin	g, such as cardia	ac or res	piratory arres	t, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Finance condition resulting in	al disease	a. Contact Gu								Death
		Sequentially list condit		Due to (or as a b.	consequence	01):						
	ine	if any, leading to imme cause Enter Underlyi	ediate	Due to (or as a	consequence	of):						
git. q	Examiner	(Disease or injury that events resulting in dea		Due to (or as a	consequence	of):						
2 0 6	dical	UNPENDED		d AMENDED								
760, cate be evented by siciar he burial	Med	IF FEMALE:		23c. If yes,	outcome of pre	gnancy					23d. Date of del	ivery
Sox 68760, leath certificate be attending physic for use as the but	sician/Me	23b. Was decedent pre past 12 months?	egnant in the	1 Live b	oirth nant at time of d		tal death 3	B Ectopic pre	gnancy		Month	Day Year
Box e death c the atten	Physic	1 Yes 2 No		wn g Unkno								
P.O. B ss that the d gned by the edetached	by P	Part II. Other significa	ant condition	s contributing to	o death but not	resulting in the	underlying cause	e given in Part I.				te to the cause of death?  Probably 4 Unknown
ords, P.O. w requires that is been signed b should be deta	sted					-			- 4	24a. Was ar	24b. Wer	re autopsy findings available
e law re e has b	Completed								-	autops;	ned? dear	
tal Rectian: The certificate ector, page	a	25. Was case referred	to medical				26.Pla	ce of Death (Che	eck only	1 Yes 2 one)	No 1	Yes 2 No
of Vital Reco	10 B	examiner? 1 Yes 2	No		Inpatient 2	ER/Outpatien					esidence 6 🗸 (	Other: Scene
Division of Vital Records, rate death.  Is after death.  In Director: After this certificate has been side in by the funeral director, page 2 should be in by the funeral director, page 2 should be in the funeral director.		27. Manner of Death  1 Natural 5	Pending	28a. Date FOUND	of Injury , Day,Year) ]	28b. Time of FOUND:	· ·   _	njury at Work? Yes 2 ✔ No	Sul	d. Describe ho bject shot	w injury occurred self	
ivision  I or Attend after death.  Director: d in by the f	ficat	2 Accident 3 Suicide 6	Investig	ation Aug 30,	***	0620 hrs home, farm, stre	LOWER BOARD		28f			or Rural Route Number, City
Divisior Hospital or Attend 24 hours after death Funeral Director: stely filled in by the	Certification	4 Homicide	determin		driveway	of residence			116	or Town, Sta 550 Mount		d, Mount Victoria, MD
Fu Fu	edical	29a. Certifier 1 Ce (Check only one) 2 Me	ertifying Phys edical Examir	ician: To the bes	st of my knowle of examination	dge, death occu and/or investiga	rred at the time, tion, in my opini	date and place, on, death occurr	and due	to the cause time, date a	(s) and manner as nd place, and due	started. to the cause(s)
To the within 2 To the complet	Med	29b. Signature and title		and manner s	stated			nse number				(Month, Day, Year)
		Allerso	Bras	ull,	UD		0.0	C.M.E.			August 31, 20	006
( ) , , (		30 Name and address Melissa Brass		o completed cau Assistant Me			Penn Street	Baltimore, N	MD 21	201		
B   NE	ite							, N	11			
Registr		_	SEP 0 1	2006	strar's Signa	D A	nerte			_		

		1 - State of Maryland / Department of Hea Certificate of De	ilth and M eath		ien <b>&amp; () () (</b> eg. No.	29466
Physiciar /Medica		1. Decedent's Name (First, Middle, Last)  Syde11 Rabenovets		2. Date of Deat Month August	28, 2006	3. Time of Death 8:20A M
Examine		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Local Laurel Regional Hospital Laurel	ation of Death		4c. County of De	
Funeral Director			Under 24 Hrs. ours Min.	8. Date of Birth (Month, Day, 12-25-1	Year) (	irthplace (State or Foreign Country) V York
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important If Item 27 Is marked other than "natural", or Items 23a or 28a-1 show any injury of other traumatic event, the Madical Examinat must be notified at 200.	by runeral	3 Wildowed 4 Divorced Year or Dates:  15. Decedent's Education 16a. Decedent's Usual Occupation	lexican, Puerto	ecify Yes or No- Rican, etc.)	Og. Citizen of What C  U.S.A.  14. Race - An Black, Wh Specify: W  16b. Kind of Busines	nerican Indian, lite, etc. hite
be filed within 72 ho tal Hygiene. d other than "naturi event, the Madical E	מ	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  4  College (1-4or 5+)  Homemaker  17. Father's Name (First, Middle, Last)	ng most of works  Mother's Name	ng o (First, Middle, M	Own Home	•
Pages 1 and 2 should been of Health and Mentin if I Item 27 is marked by go other traumatics	2	Harry Zalk  19a. Informant's Name/Relationship (Type, Print)  Harold Rabenovets— Husband  20a. Method of Disposition  1 \( \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \begin{align*} \be	Rd. #10	il Route Number 1 Silver		MD 20904 or Town, State
permit. P Departm Importar any inju		21. Signature of Funeral Service Licensee 22. Name and Address of 1091 Rockvii.	FacilitEdwa	rd Sagel	l Funeral	Direction
Physician /Medical Examiner	D	23a. Paint. Enter the disease, or complications that caused the death. Do not enter the mode of dying, su shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Metastatic Transitional Renarmal disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):				Approximate Interval Between Onset and Death
eath certificate be executed attending physician and for use as the burial-transit	200	that initiated events resulting in death) Last  Due to (or as a consequence of):  d.  IF FEMALE:			23d. Date of d	Rivery
by the ached	Ilysiciai	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  1 Live birth 2 Fetal death 5 Other (specify) 9 Unknown			Month	Day Year
w requires that been signed is should be det	5	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in PNEUMONIA	Part I.			to the cause of death?  Probably 4 Unknown
	adillos.			24a. Was ar autops perforn 1 Yes 2	y prior to ned? death?	autopsy findings available completion of cause of us 2 \( \text{No} \)
To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate completely filled in by the funeral director, page Madical Certification: To Re Co.	2	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4  27. Manner of Death 1 Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be	Nursing Hor	28d. Describe ho	ince 6 □Other (Sp w injury occurred	
spital or At ours after of seral Direct filled in by		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  29a. Certifier  1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, day		City or Town		
To the Hosp within 24 hou To the Fune completely fil		(Check only one)  2	n, death occurre	ed at the time, da	ate and place, and dual each of the signed (Morsell each of the signed (Morsell each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of the signed each of t	ue to the cause(s)
	~	30. Name and addre is of person who completed cause of death (Item 23a) (Type, Print) E.S. Malhado MD 3110 Gracefield Road Silver Spr.	ing, MD	20904		
State Registrar	_	AUG 3 1 2006 32 Ageistrar's Signature				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar		Certifica	ate of I	Death			- 9	006 2946
Physician/	Decedent's Name (First, Midd			DIIMI	TITE OF THE		2. Date of De Month	Day Year	3 Time of Death 0948 hrs
edical Examiner	MATTHEW  4a. Facility Name (if not institution		N	KUTH 4b	ERFORD City, Town, or L	ocation of		er 9, 2006	
	Upper Chesapeake N	· -			Belair			Harford	
Funeral	5. Social Security Number		(In yrs last birth	nday)	If Under 1 Year Months Days	If Under:	Min		9. Birthplace (State or Foreign
Director	219-15-2707	1 X M 2 F	30	Yrs.	Wichitis	Tiours	1/1/	/1976	co-Maryland
ě.	Usual Residence of Decedent  10a State 10b. County		10c. City, Town	or Location	n	_			10d Inside City Limits
how a	MD. H	arford			Jar	rett	sville		1 Yes 2 X No
the Maryland a or 28a-f sh iffied at once Director	10e Street and Number			T	10f. Zip Code			10g. Citizen of Wh	at Country?
uth the Maryland 23a or 28a-f show any notified at once.	3203 Chro	me Hill Ros	ad			2108	4	Unite	d States
leath with r items 23 nust be no	11 Marital Status 1 X Never Married 2 N	12. Was Decedent Armed Forces?					n? ( Specify Yes or N Puerto Rican, etc.)	o- 14. Race White	- American Indian, Black, e, etc.
ter death ", or iter er must		1 Yes 2 vorced If Yes, Give Year	<b>X</b> No	1 \	res 2 X No	specify		Specify:	White
21215-0036 uld be filed within 72 hours after Mental Hydrene marked other than "natural", event, the Medical Examiner To Be Completed by I	15. Decedent's Education (Spe	or Dates:			s Usual Occupation			16b. Kind of Bus	siness/Industry
within 72 hour within 72 hour ber than "natu ? Medical Exar ompleted	Elementary/Secondary (0-12)		+)	auring mos			se retired)	77 6	3
-003 l withii giene her th	12 17 Father's Name (First, Middle	4 4			Labo		Name (First, Middle,		rd County
21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica			utherf	ord			slie		hwastiak
D 21 nould I nd Mer is mar ritic ev	19a. Informant's Name/Relation								n, State, Zip Code) 21084
More, MD 21215-0036  Pages I and 2 should be filled within 72 hours after death with the Maryland ent of Health and Mental Hygiene out of Health and Mental Hygiene out. If item 27 is marked other than "natural", or items 23a or 28a-f she re other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	Joseph P. R	utheriord			on (Name of cem-		Date Date		sville, Md. City or Town, State
Baltimore, permit. Pages I an Department of Hea Important: If ite	1 X Burial 2 Crematic	n 3 Removal from Sta	te cremato	ory or othe	er place)				
	4 Donation 5 Other S	Specify: B	el Air	22. Na	me and Address	ens  of Facility	7/15/06	tsville	ir, Maryland , Maryland
Balti permit. Departin Imports injury o	11. Bleelder	Kurk		E.	G. Kur	tz &	Son Fu	neral H	ome, P.A.
Physician	23a. Part I. Enter the disease, of failure. List only one cause		the death Do no	t enter the	e mode of dying, s	uch as car	diac or respiratory a	rrest, shock, or hea	Approximate Interval Between Onset and
/Medical Examiner	Immediate Cause (Final diseas or condition resulting in death)			icity					Death
1	Sequentially list conditions,	Due to (or as a conse	equence or):						
iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	quence of):						
ted Insit <b>Examiner</b>	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):						
		d							
3760, ficate be execu g physician and s the burial - tra	X UNPENDED	AMENDED it.	em#23a.27.	.28a-f	.perME.g85	9.9/18	3/06 TT	23d Date of	deliver
68760, certificate be nding physici se as the buri	23b. Was decedent pregnant in past 12 months?	the 1 Live birth	2	Feta	al death 3	Ectopic p	pregnancy		Day Year
by the attendin the death certify the attendin to held for use an Physician		14 Pregnant at 9 Unknown	time of death 5	Othe	er (Specify)			3	
	Part II. Other significant cond		but not resulting	g in the un	derlying cause gr	ven in Part	I 23e. Did	tobacco use contri	bute to the cause of death?
- 8 <u>m</u> 8							1 _ Y	es 2 No 3	Probably 4 V Unknown
tal Records, itan: The law require certificate has been sig- bector, page 2 should b. Be Completed							24a Wa auto	ppsy p	Vere autopsy findings available inor to completion of cause of
Recc The lav cate ha							1 Yes		leath?  Yes 2 No
of Vital Records, ng Physician: The law requirement of the charten as been smell director, page 2 should neral director, page 2 should n: To Be Completed	25 Was case referred to medic examiner?	Hannitali				thor -	heck only one)	<u>'</u>	
of Vit ing Physic After this uneral din in: To I	1 Yes 2 No 27. Manner of Death	1 ✓ Inpatie		utpatient Time of Inj		at Work?	Nursing Home 5	Residence 6 how injury occurre	Other.
C = - ~ 1 0	1 Notural	(Month, Day, Y	ear)			es 2 X		Thow injury cooding	
Division rate of Artendir rs after death and Director: 1 led in by the fi		estigation			, factory, office bu		28f Location		er or Rural Route Number, City
Division of Vital I ospital or Attending Physician: hours after death unreal Director: After this certify filled in by the funeral director, I Certification: To Be (	4 Homicide det		nk				unk or Town,	State)	
the II the F the F mplete		Physician: To the best of my aminer: On the basis of exar and manner stated							
To Followith	29b Signature and title of certif		)		29c. License	number		29d Date signe	ed (Month, Day, Year)
	Mal	Hall	an		O.C.N	1.E.		September	10, 2006
	30. Name and address of personal Allan, MD A	on who completed cause of d ssistant Medical Exan		Penn S	treet, Baltimo	re, MD 2	21201		
State Registra		32 Registra	r's Signature	-					
DHMH 17 Rev 1/2001	. <u>SELT 9</u>	LUUD THESE	OR	GINAL					

	-	For State Registrar	State of Ma	aryland	/ Depa	artment o <i>tificate</i>	of Heal	lth and ath		Re	g. No.		29468
Physicia		1. Decedent's Name (First, Middle, Last Bertha Mario	•	edy						e of Death		006 ^{Year}	3. Time of Death  11:40 AM
/Medica	a!	Bertha Marjon  4a. Facility Name (If not institution, give		euy		4b. City, To	wn, or Loca	ation of De		ISL Z	т —	ounty of Death	11:40 AM
Examine	er	453 Bouchelle Road				E1kto					Cec	<b>i</b> 1	
Funeral		5. Social Security Number 6. Se	x 7. Age	e (In yrs. las	t birthday) Yrs.	If Under 1 \ Months D		Jnder 24 H ours N	Hrs. 8. Date (Mo	e of Birth nth, Day, L • 9	Year) Q/	9. Birthp	lace (State or Foreign hry) h East, MD
Director		213-40-1923 Usual Residence of Decedent		00	113.				Бер	L. 7,	1 1 7 4	+J NOLL	n East, Fill
rylanc show		10a. State 10b. County			Town or Lo	cation						1	0d. Inside City Limits 1 □ Yes 2 No
he Ma	ecto	Maryland Cecil		E1kt	on	10f. Zip Co	ada			10	la Citizar	n of What Cour	
With t	Ö	453 Bouchelle Road	1			219				-	*	ed Stat	
paritimities, Mary faither 212.0000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other then "naturel", or Items 23a or 28a-f show any injury or other treumatic event, Ita Medical Evantret must be routified at once.	y Funeral Directo	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:	Ever in U.S. No	'	Was Decedent f Yes, specify	Cuban, M	nic Origin? exican, Pu pecify:	? (Specify Ye uerto Rican,	s or No- etc.)		Race - Americ Black, White, pecify: Whi	etc.
hours sture!	ed by	3 ☑ Widowed 4 ☐ Divorced  15. Decedent's Ed			16a. Dece	dent's Usual (	Occupation			1	6b. Kind	of Business/Inc	dustry
dithin 72 ne. hen "na	Completed	(Specify only highest grade Elementary/Secondary (0-12)			(Give life.	kind of work o	done during retired)	g most of	working		Car	000 WII	
Hijed w Hygier thar ti	e Co	12 17. Father's Name (First, Middle, Last)			Ca	shier	18.	Mother's I	Name (First,	Middle, M		ocery mame)	
uid be dental rkad o	To B	James David Lock	ard				N	lary	Elizab	eth	Sinp	ers	
2 shou and N is mai		19a. Informant's Name/Relationship (7	ype, Print)									own, State, Zip	Code)
C, IV		Bonnie L. Jester  20a. Method of Disposition				ouchel		oad	Elktor Date			921 tion - City or To	own, State
Pages nent of H unt: If ite		1 ☑ Burial 2 ☐ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Specify		Gilp	in Ma	nation (Name natory or othe nor Ce	er place) emeter	Se 2	ptembe 2006			n, Mary	
permit. Departm Imports any injt.		21. Signature of Funeral Service Licen	WW.		12/102	Name and A		1000	Crouch North			Home 21901	
Physician /Medical Examiner		23a. Part1. Enter the disease, or compshock, or heart failure. List only disease or condition resulting in death)  Sequentially list conditions	a	ne. clasto	ma	er the mode o	of dying, su	ich as care	rdiac or respi	ratory arre	st,		Approximate Interval Between Onset and Death
o, e executed an and irial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as										
cate be exphysician the buria	dlcal		d										
is, F.O. DOX 00 (00), es that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit	hysiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal d	leath 3[	Ectopic preg Other (spec					230	d. Date of delive Month	ery Day Year
w requires that the bear signed by should be detailed	by P	Part II. Other significant conditions co	ontributing to death b	ut not result	ting in the u	nderlying cau	ise given in	Part I.	23	le. Did tob 1 □ Ye			he cause of death? pably 4 []Unknown
The lar	completed								_	a. Was ar autopsy perform Yes 2	/	prior to co death?	psy findings available mpletion of cause of
VICAL iclen: 1 certificat ector, p	Be C	25. Was case referred to medical examiner?	HN-E					. Place of	Death (Chec	k only one	9)		
5 £ E E	5.	1 Yes 2 No	Hospital: 1 ☐ Inpation		R/Outpatier 28b. Time o			1 🗌 Nursir	-	X Reside		Other (Specif	(y)
After	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Da	y Year)	Injury	М	work?	2 🗆 No					
To the Hospital or Attending F within 24 hours after death. To tha Funeral Director: After completely filled in by the funeri	Certification;	3 Suicide 6 Could not be determined		ury - At hon c. (Specify)	ne, farm, st	reet, factory, o	office		28f. Lo Cit	cation (Str y or Town	eet and N , State)	Number of Rura	al Route Number,
the Hospitel or hin 24 hours afte tha Funerel Dirr mpletely filled in h	edical (		ysician: To the best niner: On the basis of and manner st	f examination	on and/or in	vestigation, in	n my opinio	n, death o	occurred at th	ne time, da	te and pla	ace, and due to	o the cause(s)
To the To the Comp	W	29b. Signature and thie at certifier	and manner st			29c. I	License nu	mber 053	3	29	d. Date s	signed (Month,	Day, Year)
6		30. Name and address of person who	ompleted cause of	death (Item 2	23a) (Type,	Print)	E	18To	in.	nd	2	1921	
Sta Registr		SEP 1 2006	32. Registr	rar's Signatu	GOGA								

			1 - For State Registrar	State	of Maryla	•	artment of F		ind M			2006	2946	9
	Dhusisi		1. Decedent's Name (First, Middle	, Last)						2. Date of Dea Month	th Day	Year	3. Time of Death	
	Physici: /Medic		Margaret	Α.		Schwa	rtzberg			August	27	2006	9:10 p M	
	Examin	er	4a. Facility Name (If not institution			_	4b. City, Town, o	r Location of	f Death			ounty of Death		
			Genesis Elder				Annapol		04 Hre	a Data of Diah		ne Arur		_
	Funeral		5. Social Security Number 217-56-2862	6. Sex 1 ☐ M 2 💢 F		rs. last birthday)  8 Yrs.	Months Days	Hours	Min	8. Date of Birth (Month, Day Sept 8	(Year)		nplace (State or Foreigr untry)	3
	Director		Usual Residence of Decedent			-				sept o	131/	Mai	cyland	
	yland ***		10a. State 10b. County		10c.	City, Town or Lo	ocation						10d. Inside City Limits	
	Mar.	to	MD Anne	Arundel		Annap	olis						1 ☐ Yes 2X No	
	h the	Funeral Director	10e. Street and Number				10f. Zip Code				10g. Citize	n of What Co	untry?	
	th wil	alD	694 Melrose St	reet			2140	)1				USA		
	eep .	ner	11. Marital Status		ecedent Ever in Forces?	1 U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Orig an, Mexican,	jin? (Spe , Puerto F	cify Yes or No- Rican, etc.)	14	. Race - Amer Black, White		
36	72 hours after deeth with the Maryland natural', or Items 23a or 28a-f ehow itsal Examinar must be incitiliad al	by Fu	1 Never Married 2 Marr	If Yes,	s 2 <b>X∭</b> No Give		1 ☐ Yes 2 🛣 No	Specify:				pecify:	White	
ë	hours tural'	d b	3XXWidowed 4 □ Divorced		Dates:	16a Door	dent's Usual Occup	ation			16h Kind	of Pusinoss/I	Deluging	
15	n 72 n nat	Completed	(Specify only highe	t's Education of grade complete	d)	(Give	kind of work done  DO NOT use retired	during most	of workir	ng	IOD. KIIIG	of Business/I	ridustry	
12	within ene. then *	mc.	Elementary/Secondary (0-12)	Cotlege	(1-4or 5+)		maker	,			Owi	n Home		
D 2	e filed Il Hygie other	BeC	17. Father's Name (First, Middle,	Last)				18. Mother	r's Name	(First, Middle,	Maiden St	ımame)		
lan	should be and Mental marked o	To B	George Saffiel	d				E1	la K	irby				
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after deeth with the Marylan if Health and Mental hydrens the Properties or 1884 of show Item 27 is marked other then "natural", or items 23a or 28a-1 show other treumatic event, the Madical Examinar must be notified at		19a. Informant's Name/Relations	hip (Type, Print)		19b. Maili	ng Address (Street	and Number	r or Rura	Route Numbe	r, City or 1	own, State, Z	ip Code)	
	s 1 and 2 of Health a Item 27 is other tre		Rebecca Owen (	Daughter			Melrose S	Street	CARL PARTY		-		u	
ore	of Ho		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 □Removal fro		<ul> <li>Place of Dispose</li> <li>cemetery, cre</li> </ul>	osition (Name of matory or other plac	сө)	D	ate	20c. Loca	tion - City or	Town, State	
Ë	Pag ment ent:		4 □ Denation 5 □ Other (S			neseth	Israel Ce	em. 8	-29-	2006	Annap	olis,	MD	
Baltimore,	permit. Pages of beganding the partment of the temportent: If the eny injury or of once.		21. Sign ture of Funeral Service	Licensee		2	<ol> <li>Name and Addre Hardesty</li> </ol>	ss of Facility Fune	ral	Home, P	.A.			
	0 □ # • Q		2000	P			12 Ridge	ly Av	enue	, Annap	olis	MD 21	Approximate	_
			23a. Pa (1. Enter / disease, or shock, or heat failure. List	only one cause of	n each tine.						rest,		Interval Between Onset and Death	
	Physician /Medical		In mediate Cauve Final diser e or con litir n r se liting in de tr	a			emic C	cv 1;	m	with			140	
	Examiner		80	Due	to (or as a cons	sequence of):							,	
		ē	Sequentially list conditions,	b. Due	to (or as a cons	sequence of):								_
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	G										
ó	death certificate be executed e ettending physician and d for use as the burial-transit	Exa	resulting in death) Last		to (or as a cons	sequence of):								
8760,	ite be iysicii ne bu	cal		d										
9	ng ph	Med	IF FEMALE:							0-000000				
Вох	death certifica ettending ph d for use as th	an/I	23b. Was decedent pregnant in the past 12 months?		outcome of pre e birth 2 🗆 F	etal death 3	□Ectopic pregnanc	у			23	d. Date of deli Month	very Day Year	
	it the dea by the el tached fo	Physician/Med	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pre 9□Un	egnant at time o known	of death 5 (	Other (specify)						54,	
P.0	that the ed by detacl		Part II. Other significant conditi	ons contributing to	death but not	resulting in the	inderlying cause on	en in Part I		23e. Did to	bacco use	contribute to	the cause of death?	
Vital Records,	se G e	1 by	, and a sense of	one continue and the	3 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	1000	2.1.do.1, 11.1g = 2.00 g.1			1 🗆 Y	_			,
Ö	w requir been si should	Completed								24a. Was		04h 18/ara au	topsy findings available	_
Rec	has ge 2	ш								autop perfor	sy	prior to death?	completion of cause of	'
<u>e</u>		e Co	25. Was case referred to medica					00.00			2 2100	1 🗆 Yes	2 No	_
<u>=</u>	Physician: This certificated director, p	00	examiner?	Hospital:	☐ Inpatient 2	2 ☐ ER/Outpatie	ot 30 DOA Ot	ner -		n <i>(Check</i> on <i>ly o</i> me 5 □ Resid		Other (Spe		
ð	4 = 5	<u>ات</u>	27. Manner of Death		te of Injury lonth, Day Year				-	28d. Describe h			ary,	
ioi	Attending I r death. ector: After by the funer	atlo	1 Natural 5 Pendir 2 Accident investi	9	ionin, Day 19ai	r) Injury		rk?  Yes 2∐1	No					
Division of	or Attend efter death   Director: ,	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	100d 200. Pic	ace of Injury - A	At home, farm, si	treet, factory, office		1	28f. Location (S City or Tow		Number or Ru	iral Route Number,	
Ö	rs efferal or	Ce				,,								
	To the Hospital or within 24 hours efter To the Funeral Dirticompletely filled in I	Medical	29a. Certifier Cartifyin (Check only 2 Madical one)	Examinar: On the	the best of my e basis of exam anner stated.	knowledge, dea nnation and/or in	th occurred at the ti nvestigation, in my o	me, date and opinion, deat	d place, a th occurre	and due to the ded at the time, o	cause(s) a date and p	nd manner as lace, and due	stated. to the cause(s)	
	Vithir Comp	Σ	29b. Signature and title of certifie	7			29c. Licens		21		í	signed (Monti		
,			13 1	mini	/			3)9				1819		
_	6		30. Name and address of person	vose	2-11	18 0.	Print)	Dri	re	Cho	.k.	Ma.	11419	
	Sta Regist		31. Date filed (Month, Day, Year)	2006	Aegistrar's Si	ignature	and .						*	

		•	1 - For State Registrar	State of Ma	aryland / De	epartment of H Certificate of I	ealth and M Death	lental Hygie	2006	29470					
ı	Physicia	_	1. Decedent's Name (First, Middle, La James Francis	51)				2. Date of Death	25, 2006	3. Time of Death 12:30 A M					
	/Medic Examin		4a. Facifity Name (If not institution, giv	street and number)			Location of Death		4c. County of Deat Anne Aru						
	Funeral Director	- 1	Anne Arundel Medi  5. Social Security Number  371–42–9136		in yrs. last birtho 64 Yr	Months Davs	If Under 24 Hrs.	8. Date of Birth Month, Day, Y March 12	9. Birti	hplace (State or Foreign unity) higan					
	D		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	or Location			, - , - , - , - , - , - , - , - , - , -	10d. Inside City Limits					
	Maryla -f ehov	ţŏ	Maryland Anne Aru	ndel	Edgewate					1 ☐ Yes 2 🗓 No					
	h with the 23a or 28a 1st be noti	Direc	10e. Street and Number 3313 Leritz Lane	.,,		10f. Zip Code 21037		10g US	g. Citizen of What Co	untry?					
36	be filed within 72 hours after death with the Maryland tal Hygiane. Id other then "natural", or itema 23a or 28a-f ehow event, the Medical Examinar must be putified at	by Funeral	11, Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces?  1 1 12 Yes 2 1 1 Yes, Give Year or Dates:	Ever in U.S. 10 1964–1994	13. Was Decedent of H ff Yes, specify Cube 1 Yes 2 No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh						
21215-0036	thin 72 hou e. en *natura Medical E	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) College (1-4or 5	16a. D	ecedent's Usual Occup Give kind of work done of ife. DO NOT use retired	during most of work f)	ing	6b. Kind of Business/	Industry					
	Hygint, Int.	Con	17. Father's Name (First, Middle, Last	5+	US I	Naval Offic		e (First, Middle, Ma	aiden Sumame)						
Vlan	should be nd Mental merked o	To Be	John	Sh	anahan ——		Beatrice		Mulc						
, Maryland	end 2 sho selth and n 27 le m		Sandra C. Shanaha		3313	Mailing Address (Street) 3 Leritz Ln	.,Edgewat	er,MD 210	037						
altimore,	permit. Pages 1 and 2 should be Depertment of Heelth and Menta Important: If Item 27 Ie marked any Injury or other treumatic e <u>90ce</u> .		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Special		20b. Place of Cometery, Arlingto	Disposition (Name of crematory or other place on National	Cemetery	Ar.	ington, V	/irginia					
Ball	permit Depert Import any In		21. Signature Funeral Service Licensee  George F. Kalas Funeral Home, P.A. 2973 Solomons Island Rd., Edgewater, MD 21037  23a. Parti Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate												
I	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused one cause on each lii	10.	t enter the mode of dyin	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death					
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of					-					
	uted d ansit	Examiner	Sequentially list conditions, if any, had ling to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Qualto (or as	a nonsequence of	·									
68760,	ficate be executed physicien and is the burial-transit	dical Exa	resulting in death) Last	Due to (or as	a consequence of	):									
_	artificat ling phy e as th		IF FEMALE:												
P.O. Box	he death certifi the attending f ched for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 Ectopic pregnancy 5 Other (specify)	<i>'</i>	<del></del>	23d. Date of dei Month	livery Day Year					
	law requires that the deas been signed by the a	ď	Part II. Other significant conditions	contributing to death b	ut not resulting in t	he underlying cause giv	en in Part I.			o the cause of death? robably 4 []Unknown					
Division of Vital Records,	The ate h	Completed					_	24a. Was an autopsy performe	ed? prior to death?	utopsy findings available completion of cause of					
Vita	lcian: cartifica ector,	Be	25. Was case referred to medical examiner?	Hospitaf:		Oth	ec	th (Check only one							
l of	ter this	on: To	1 ☐ Yes 2 ☑ No  27. Manner of Death 1 ☑ Natural 5 ☐ Pending	1 Afnpatie 28a. Date of Inju (Month, Da	ry 28b. Tir	atient 3 DOA	4 □ Nursing Ho	ome 5 Resident 28d. Describe how	nce 6 Other (Spe v injury occurred	cify)					
ivisio	To the Hospitel or Attending Physician: within 24 hours effar death. To the Funeral Director: After this cartifica completely filled in by the funeral director;	Certification:	2 Accident investigation 3 Suicide 6 Could not to 4 Homicide determined	e One Place of Ini	ury - At home, farr c. (Specify)	M 1	Yes 2 □No	28f. Location (Stre City or Town,	eet and Number or Ri State)	ural Route Number,					
٠	To the Hospitel of within 24 hours of To the Funeral D completely filled in	edical Ce	(Check only 2 Medical Exa	miner: On the basis o	f examination and	death occurred at the tir or investigation, in my o									
	To the within 2 To the complete	Med	29b. Signature and title of certifier	Beck, M		29c. Licens	e number 6052	29	d. Date signed (Mont	th, Day, Year)					
•	,51		30. Name and address of person who	completed cause of o	leath (Item 23a) (T	ype, Print Parhwa	y, ann	apolis, 1	1						
	Sta Regist	ite	31. Date filed (Month, Day, Year)  AUG 2 9		ar's Signature	Soull .	<b>V</b> /								

			State of State of Registrar	Maryland / Depa	artment of Healt			e 2006	291.71
			Decedent's Name (First, Middle, Last)	<del></del>			Date of Death		3. Time of Death
	Physici		Ernest E. Smith				Month 0	8,2006	8:58 PM
,	/Medic Examin		4a. Facility Name (If not institution, give street and numb	er)	4b. City, Town, or Locati	ion of Death		c. County of Death	
	Exami	Ų.	WMH5-Beaddock Cam	pus	Cumber	land		ALLEGA	
	Funeral			Age (In yrs. last birthday)	If Under 1 Year If Un Months Days Hou	nder 24 Hrs. 8.	Date of Birth (Month, Day, Yea	9. Birthp Coun	lace (State or Foreign try)
	Director		235-52-5108 ¹ \(\text{\$\text{\$M\$}}\) \(^2\) \(^1\)	71 Yrs.			eb. 17,1		ser, WV
	p .		Usual Residence of Decedent  10a, State 10b, County	10c. City, Town or Lo	ncation			1	0d. Inside City Limits
	aryla •ho	5		,					1 X Yes 2 □ No
	he №	Director	WV Mineral  10e. Street and Number	Keys	10f. Zip Code		10g. (	Citizen of What Coun	itry?
	with		745 Armstrong Street		26726		5	USA	,
	ns 23	eral	11. Marital Status 12. Was Deced	ent Ever in U.S. 13.	Was Decedent of Hispanic If Yes, specify Cuban, Mex	c Origin? (Specify	Yes or No-	14. Race - Americ	an Indian,
_	iter d	Funeral	1 Never Married 2 Married 1 Yes 2	□No			an, etc.)	Black, White,	etc.
2	urs al	ρ Ω	If Yes Give	es:1953-61	1 ☐ Yes 2 🎇 No Spe	icify:		Specify: Wh	ite
1215-003b	2 ho	ted	15. Decedent's Education	16a. Dece	dent's Usual Occupation kind of work done during	most of working	16b.	Kind of Business/Inc	dustry
Ž	thin 7	pie	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4)	life.	DO NOT use retired)	most of working			
7	filed within 72 hours after death with the Maryland Hygiene. other than 'natural', or Items 23e or 28e-f ehow ent, the Madical Examinational Se nutilian at	Completed	11		Tank Tende			lass Manu	facturing
2	be filed within 72 hours after death with the Marylan tal Hygiene. d other than "natural", or Itama 23a or 28a-1 show event, the Madical Examination must be nutities at	Be	17. Father's Name (First, Middle, Last)		18. M	Nother's Name (F	irst, Middle, Maid	en Sumame)	
<u>×</u>	should to marke umatic	은	Maurice Maxwell Smith				Louise C		0-4-1
Maryland 2	and rand		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Nu				
	s 1 and 2 should be filed of Health and Mental Hygis Item 27 is marked other other traumatic event, II		Karen S. Burns/Daughter 20a. Method of Disposition	20b. Place of Dispo	3 Maryland Fosition (Name of	Date		n, MD 21.	
altimore,	0 0		1 M Burial 2 □ Cremation 3 □ Removal from St	ate cemetery, cre	matory or other place)	Sept.	13		
	permit. Pag Department Important: any injury once.		4 Donation 5 Other (Specify)  21. Signature Properal Service Licensee		Point Cemete 2. Name and Address of F		lein -	Keyser, W	IV
Ba	permit. Pag Department Important: i any injury o		18 Town Front		85 S. Main S	Smil	th Funer Keyser,		26
			23a. Part1. Enter the disease, or complications that car	used the death. Do not en				W V 207	Approximate Interval Between
			shock, or heart failure. List only one cause on each	ch line.	LUNG C				Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	r as a consequence of):	Carlotto -				
	Examiner			. 20 2 00.1004 00.110					
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	r as a consequence ol):					
	outed id ansit	Examiner	Cause (Disease or injury that initiated events						
o Ô	en ar	E	resulting in death) Last Due to (o	r as a consequence of):					
8760	cate be executed physicien and the burial-transit	dical	d						
99	ing of as t	Med	IF FEMALE:						
Вох	eath certific ettending p for use as	an/	23b. Was decedent pregnant 1 Live bir		Ectopic pregnancy			23d. Date of delive Month	ery Day Year
o.	ires thet the death certific signed by the ettending p d be deteched for use as	by Physician/Med	1 ☐ Yes 2 ØNo 4 ☐ Pregna 9 ☐ Unknown 9 ☐ Unknown		Other (specify)				
ď.	het the	4	Part II. Other significant conditions contributing to dea	th but not resulting in the	underlying cause given in F	Part I.	23e. Did tobacc	o use contribute to t	he cause of death?
ds,	sign d be						1 📈 Yes	2 No 3 Prot	pably 4 Unknown
Ö	w requir been si should i	ete					24a. Was an	24h. Were auto	ppsy findings available
Re	he lav	Completed					autopsy	prior to co	impletion of cause of
ā	n: Ti ficate or, pa	e Co	25. Was case referred to medical		26.1	Place of Death (0	1 Yes 200	No 1 ☐ Yes	2 No
5	s cert irect	To B	examiner?	patient 2 ER/Outpatie	Other		1	6 ☐Other (Special	(v)
ō	g Phy er this eral c	Ë	27. Manner of Death 28a. Date of				1. Describe how in		,,
<u>o</u>	nding ath. r: Ath e fun	atio	1 Natural 5 Pending (Month 2 Accident investigation	, Day rear) Injury	M 1 ☐ Yes	2 🗆 No			
Division of Vital Records, P.O.	er des	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place 6 buildin	of Injury - At home, larm, sig, etc. (Specify)	treet, factory, office	28f	Location (Street City or Town, S	and Number or Rura tate)	al Route Number,
۵	rs after or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all or all	Cer							
	To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate hes been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit	edical	29a. Certifier 1 Certifying Physician: To the la (Check only 2 Medical Examiner: On the bar	sis of examination and/or is					
	the the the the the mplet	Med	one) and manni 29b. Signature and title of certifier	er stated.	29c. License num	nber	29d.	Date signed (Month,	Day, Year)
	8 18.1		Alixo Podli	11	D00 6	346 7		09/109	106
•	.0		30. Name and address of person who completed cause	of death (Item 23a) (Type		740 1		,(0,	
	1.0		AUDA POSPELTAN	904 Set	on Drive	Cumh	erland	mo 21	502
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3	Regist	rar	SFP 1 5 2006	and the Be	DAD!				

			1 - For State Registrar	State of Ma	arylan		artmen rtificat							06	29472
	Physici	an	Decedent's Name (First, Middle, La     Jean Diane	st) Scafidi	Ĺ						2. Date of De Month Aligust		ğ.	2 ^Y 006	3. Time of Death 10:30 AM
	/Medic Examir		4a. Facility Name (If not institution, giv				4b. City,	Town, or	Location of	of Death				of Death	10,00
			2403 Honeystone	Way	4				ville	D4 Hrs			Mont	gomer	
	Funeral Director		5. Social Security Number 6. S 220–58–7217	_	6 (In yrs. 1 55	last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bir Month, Da July I	th (19)	51	9. Birthpl CallI	ace (State or Foreign try) Ornia
	D		Usual Residence of Decedent  10a, State 10b, County		10a Cib	y, Town or Lo	antina			1.				14	3d Jasida City Limita
	Maryla f shov	or	10a. State 10b. County  Maryland Montge	nmerv		okevi								'	0d. Inside City Limits  1 Tyes 2 No
	th the l	lrect	10e. Street and Number				10f. Zip					-		What Coun	•
	s 23a c	ralD	2403 Honeystone		• •	0 10		208		-1-0-(0	4 14			State	
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show mingrant: Injury or other traumatic event, it in Medical Examiner must be muited at once.	Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 → Married 3 □ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces?  1 Yes 2 No If Yes, Give 2 Year or Dates:		ĺ	was Deced If Yes, spec		ispanic Ori in, Mexicar Specify:		cify Yes or No lican, etc.)	) <del>-</del>		ce-Amenc ck, White, o y: Whi	etc.
5-0	72 ho	eted	15. Decedent's E (Specify only highest gra	ducation ade completed)		16a. Dece (Give	dent's Usua kind of wo	ol Occupa	ation during mos	t of workin	g	16b. K	ind of B	usiness/Ind	lustry
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Baltimore,	permit. Departm Imports any inju		21 Signature of Funeral Service Lice	Shipart		9	33 Gf:	st A	ve	LL Si	lver :	pri			vice, P.A.
	1		23a. Part1. Enter the disease, or or me shock, or he in allure. sist only	plications that caused one cause on each lin	the death	n. Do not ent	er the mod	e of dyin	g, such as	cardiac or	respiratory a	rrest,	1,100.00	No. Service	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Multipl			is							1	0 years
8	Examiner			Due to (or as	a conseq	uence of):									
	st st	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a conseq	uence of):									
,0928	cate be executed physician and the burial-transit	dical Examiner	that initiated events resulting in death) Last	c Due to (or as a	a conseq	uence of):									
O. Box 6	death certific e attending p id for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 🗌 Feta	Ideath 3	Ectopic pr Other (sp							ite of delive	ry Day Year
ds, P.	es pe	þ	Part II. Other significant conditions	contributing to death be	ut not res	ulting in the u	nderlying c	ause give	en in Part I			obacco Yes 2			e cause of death? ably 4 Unknown
Records,	aw 2 s	Completed						-			24a. Was auto perfo			Were autop prior to con death? 1  Yes	osy findings available appletion of cause of
Vital	Physicien: this certificatal director, p	Be	25. Was case referred to medical examiner?	(In anital)				0#			(Check only	one)			
of	Physi r this o	. To	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 ☐ Inpatie	γ	ER/Outpatier 28b. Time of		8c. Injury	/ at		e 5 <b>½</b> Resi 8d. Describe				)
ion	Attending or death. ector: After by the fune	atlor	1 ⊠ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	(Year)	Injury	М	Work	k? Yes 2□	No					
Division	in Pitte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ury - At ho c. (Specify	ome, farm, str	eet, factor	, office		2	8f. Location ( City or To	Street ar wn, State	nd Numl e)	ber or Rura	Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	edical (		nysician: To the best on miner: On the basis of and manner sta	examina										
	To the Vithin 2 To the Complet	W	29b. Signature and title of certifier				290		e number					d (Month, L	
	5		July 1	-/		- 00-) 7	2-1-1	D	18726		P	ugus	st 3	0, 20	06
			30. Name and address of person who Arthur Schoengole			Prince		ldn 1	Dr ⊓	-10 0	1nor-	MT) '	2002	2	
	Sta Regist		31. Date filed (Month, Day, Year) AUG 3 1	2006 32. Jegistra	ar's Signa	B. A	rede	) r.+h1	<del>***</del>	-±V (	titey,	****** x	<del>: VO 3</del>	2-	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 29473 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Month 09/01/2006 6:00 AM Regina A. Snyder /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 774 Ocean Parkway Ocean Pines Worcester If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/12/1941 Birthplace (State or Foreign Country)
 PA 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 M XXXF 65 Director 193-32-0159 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location *ohe 10a. State 10d. Inside City Limits ?7 is marked other then "natural", or items 23a or 28a-f ebov treumatic event, the Madical Examinar must be notified at Director 1 ☐ Yes 2X No Ocean Pines MD Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 774 Ocean Parkway 21811 Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiane. 1 Yes 27 No 1 Never Married Married Baltimore, Maryland 21215-0036 β 1 ☐ Yes ŽXNo Specify: Specify: White If Yes, Give-Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiane. Elementary/Secondary (0-12) College (1-4or 5+) US Government Administrator 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Helen Zientek Joseph Smith 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is eny Injury or other trea once. 774 Ocean Parkway Ocean Pines, MD 21811 John L. Snyder (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2XX Cremation 3 Removal from State 4 Donation 5 Other (Specify) 09/04/2006 Frankford, DE Cape Henlopen Crem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 234. Part1. Enter the tukease, or complications that caused the beath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 108 William Street Berlin, MD 21811 Approximate Interval Between Onset and Death LIVER FAILURE Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine PREASE Hospital or Attending Physician: The law requires that the death certificate be executed inding physician and use as the burial-transit BRENDRY Due to (or as a consequence of): Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atter for u 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) Records, P.O. 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed Yes 2 No 2□ No 1 Yes 1□ Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 2 ER/Outpatient 3□ DOA his 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending death. 1 □ Yes 2 □ No investigation 2 Accident hours after death the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 - Homicide To the Hospital within 24 hours a To the Funerat C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and margner stated. Medicai (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MD-D0046255 09/01/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 314 Franklin Ave. Suite 304 Berlin, MD 21811 Jonathan Bell 31. Date filed (Month, Day, Year) State SEP 0 5 2006

DHMH 17 Rev 1/2001

Registrar

06-06487

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene Walter Scott Turner 74

		1- For State Registrar	Certific	ate of Death		Reg.	No. 200	6 2947
Physicia ledical Exami	n/	Decedent's Name (First, Middle,Last)  WALTER SCOTT TURNER				Date of Death Month D Nugust 29, 2	Day Year 2006	3. Time of Death 1840 hrs
		4a. Facility Name (if not institution, give street and number) Peninsula Regional Medical Center		4b. City, Town, or Salisbury	Location of Death		4c. County of Death Wicomico	
Funeral Director		5. Social Security Number 6. Sex 7. Age 229-92-9085 1 M 2 F	e (In yrs. last birt	hday) If Under 1 Yea Months Day	s Hours Min.	. Date of Birth(	MM/DD/YYYY) 9. Birt Foreigi 1955 Cou	
any	F	Usual Residence of Decedent  10a State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
* .	'n	MD Worcester	Pocomo	ke City				1 Yes 2 X No
th the Maryland 23a or 28a-f sho notified at once.	Director	10e Street and Number 1514 New Bridge Road		10f. Zip Code 21851		10g	Citizen of What Coun	try?
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f shematic event, the Medical Examiner must be notified at once	Fune	11. Marital Status 1 Never Married 2 X Married Armed Forces? 1 Yes 2 3 Widowed 4 Divorced If Yes, Give Year	Ever in U.S.	13. Was Decedent of Hi If Yes, specify Cubar	n, Mexican, Puerto Ric		14. Race - Americ White, etc.	
hours at natural	ed by	15. Decedent's Education (Specify only highest grade com		Decedent's Usual Occupa during most of working life	ition (Give kind of work		6b. Kind of Business/Ir	
36 hin 72 } e than "1	ompleted	Elementary/Secondary (0-12) College (1-4 or 6	5+)	borer	,		Wharehous	se.
21215-0036 uld be filed within 7 Mental Hygiene marked other that	ပ	17. Father's Name (First, Middle, Last)			18.Mother's Name (Fi	rst, Middte, Ma	iden Surname)	
121 d be fil fental F narked	o Be	Robert L. Turner  19a. Informant's Name/Relationship (Type, Print )	140	h Mailian Address (Cha	Evelene	Drewe	r	7' 0-4-)
nore, MD 21215-0036 ages I and 2 should be filed within 72 nt of Health and Mental Hygiene It: If Hem 27 is marked other than other traumatic event, the Medical	۲	Drenda Turner/ Wife	1	b. Mailing Address (Street 514 New Broof Disposition (Name of ce	cidge Roa	d, Po	comoke Ci	ty, MD
Baltimore, MD permit. Pages I and 2 she Department of Health and Important: If item 27 is injury or other traumati	1	20a. Method of Disposition  1	remat First	of Disposition (Name of ce ory or other place) Bapt • Cen	$n_{\bullet} = 0.00$		6 Pocomok	
Balti permit. Departm Importa injury o	- 1	21 Signature of Fur and Service Licensee						Iome, P.A.
Physician	-	23a. Part I. Enter the disease, or complications that caused	the death. Do no					MD 21851 Approximate Interval
/Medical, Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic Due to (or as a conse		lar Disease				Between Onset and Death
		Sequentially list conditions, b						
	niner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	equence of):					0
ited d ansit	Examin	events resulting in death) Last  Due to (or as a conse	equence of):					
760, icate be executed physician and the burial - transit	/Medical	UNPENDED AMENDED						,
Box 68760, re death certificate be the attending physicined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use as the burined for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcor 1 Live birth 4 Pregnant at 9 Unknown		Fetal death 3  Other (Specify)	Ectopic pregnancy		23d. Date of delivery Month D	ay Year
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cords law requ	Completed	-				24a. Was an autopsy performed 1 Yes 2	prior to o ed? death?	opsy findings available ompletion of cause of
Vital Rec ysician: The his certificate	Be	25. Was case referred to medical examiner?			e of Death (Check only	one)		
f Vid Physic er this	ဥ	examiner? 1 Yes 2 No Hospital: 1 Inpatie  27. Manner of Death 28a. Date of Inju		· Land	Other Nursing H	Laurend	esidence 6 Others	
ion of vertices. After the funeral	tion:	1 Natural 5 Pending (Month, Day,Y	ear)		Yes 2 No	a. Describe no	willigary occurred	
Divisic pital or Atte ours after des ceral Directo filled in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	jury - At home, fa	arm, street, factory, office	building, etc. 281	f. Location (Street or Town, State	eet and Number or Rui te)	al Route Number, City
To the Hosp within 24 ho To the Function	Medical C	29a Certifier (Check only one) 2 Medical Examiner: On the basis of examiner and manner stated			·		,	
F > F 5	ž	29b. Signature and title of certifier $m$ , $m$ $\omega$		29c. Licen	se number .M.E.		29d. Date signed <i>(Mor.</i> August 30, 2006	th, Day, Year)
BAIR		30. Name and address of person who completed cause of c Ling Li, MD Assistant Medical Examine		n Street, Baltimore,	MD 21201			
St	ate	31. Date filed (Month. Day Year) 32. Redistra	r's Signature	1				
Regis	rar	SEP 0 1 2006	m &	19 may			<del></del>	

			For State Registrar	State of M	1arylan		artmen rtificate					giene Reg. No. 2	006	29475
	Physicia	an	Decedent's Name (First, Middle,	, Last)	<u> </u>						2. Date of De Month	ath Day	Year	3. Time of Death
-	/Medic	al	Travis Eas		1620	0	45 (2)5.	Ta	A malakina a	- 1 D- 01h	Septer		200 Le	5 . 32 PM
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À.	Funeral					last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Bird	th	9. Birthp	lace (State or Foreign
	Director		220-28-2960	1 <b>⊠</b> M 2□F	74	Yrs.	Months	Days	Hours	Min.	July 2	9,1932	West	Virginia
	pu .		Usual Residence of Decedent  10a. State 10b. County		10c Cit	y. Town or Lo	ocation						1	0d. Inside City Limits
	Aaryia Fahor	ō		ington			rstow	n					]	1 ☐ Yes 2√€ No
	28a-	Directo	10e. Street and Number	ingcon		nage	10f. Zip					10g. Citizen o	of What Cour	ntry?
	h with		17834 Virginia	a Avenue					21740	)		US	A	
	deet and	Funeral	11. Marital Status	12. Was Deceder Armed Forces	t Ever in U.	S. 13.	Was Deced	tent of His	spanic Ori	igin? (Spe	ecify Yes or No Rican, etc.)	- 14. R	ace - Americ	
9	72 hours after deeth with the Maryland Insturat', or itama 23a or 28a-f ahow Jical Examinat must be incilled at		1 ☐ Never Married 2 2 Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 Tes 2 If Yes, Give	<b>X</b> No		1 ☐ Yes				,,	Spec		√hite
215-0036	n 72 hours natural', olicel Exe	Completed by	15. Decedent	Year or Dates	i.	16a. Dece	dent's Usua	il Occupa	ition			16b. Kind of	Business/in	dustry
5	e filed within 72 ho al Hygiene. other then "netur vent, the Medical	plet	(Specify only highest Elementary/Secondary (0-12)		r 5±)	(Give	kind of wo DO NOT us	rk done d se retired)	l <i>uri</i> ng mos )	t of worki	ng			,
	d within giene. ar than	Com	7	0	31,	lot	atte	ndant	t			aut	o sale	es
2	be filed tal Hygie d other event, II	Be	17. Father's Name (First, Middle, L								(First, Middle,			
<u>\Z</u>	2 should be and Mentai is marked raumatic ev	2	Phillip H. Thom  19a, Informant's Name/Relationsh			105 14-33		(644			Pearl (			. 0-1-1
Maryland 2			Jacqueline B. T		zifo						<i>  Route Numbe</i> agersto			
	of Health itam 27 other tr		20a. Method of Disposition	. Hompson	20b. P	face of Dispo	sition (Nan	ne of			ate	20c. Locatio	_	
0 E			1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		8	emetery, cre se Hil.	-			9/7/	06	Hagers	town.	Maryland
Baltimore,	permit. Pag Department Important: t eny injury o once.		21. Signature of Funeral Service L		1						NICH FU			
m	82729		Total	11/11/11	mu		·		-		, Hager		Md. 2	21740
П			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	rdia		res	†						Immediate
	Examiner			Due to (or a	resti	1 1	ieart	Fo	ulu	10				VACYS
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a			vece.		CC 101	<u> </u>				4 0013
	cuted nd ransit	Examin	that initiated events	U	1	ipid	einic	2						years
Ď	be executed sician and burial-transit	Ex	resulting in death) Last	Due to (or		uence of):								\$10065
8/60	ate the	dical		a. Trye	Deite	1 510								years
Box 6	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom								23d. (	Date of delive	ary
	death e atte	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant	at time of de		□Ectopic pr □ Other <i>(sp</i>					1	Month	Day Year
O.		hys	9 🗌 Unknown	9□ Unknown										
	iaw requires that the de as been signed by the a 2 should be detached t	by	Part II, Other significant condition	ns contributing to death	bul not resi	ulling in the u	nderlying c	ause give	n in Part I.	•				ne cause of death?
Vital Records,	w require been sli should b	Completed									-	Yes 2□No		
Hec	0 - 0	ldm									24a. Was autor perfo		prior to con death?	psy findings available mpletion of cause of
e e	iician: Th certificate rector, pag		25. Was case reterred to medical						OC Blees	of Dooth	1 ☐ Yes (Check only o	2 No	1 🗆 Yes	2 No
	S w D	To Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpa	tient 2 🗹	ER/Outpatie	n1 3□ DC	Othe	100		ne 5∐ Resid		ther (Specif	v)
Ö	ding Ph h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☑ Pending	28a. Dale of In	jury Day Year)	28b. Time o	f 2	8c. Injury Work	at	1	28d. Describe I	how injury occ	urred	
<u>                                      </u>	ttendir death. ctor: Al	catic	2 Accident investig	ation			М	1 🗆 1	res 2 🗆					
Division of	F 6 F C	Certification:	4 Homicide determi	ned   286. Place of I	njury - At ho etc. <i>(Specif</i> )	ome, larm, st y)	reet, factory	, office		1	281. Location (S City or Tox		mber or Rura	il Route Number,
	To the Hospitel of within 24 hours at To the Funeral D completely filled in		29a. Certifier 1 Certifying	g Physician: To the bes	st of my kno	wiedge, deat	h occurred	at the tim	e, date an	nd place, a	and due to the	cause(s) and	manner as s	tated.
	the Hone Hone Hone Hone Fu	ledical	one)	Examiner: On the basis and manner		arid/or ir	_			in occurr				
	or with	Σ	29b. Signature and title of certifier	Ill	n	an		: License	052	121		29d. Date sign	med (Month,	
			30. Name and address of person v	who completed cause of		7 (Type						1		0
0	4-4		KJill Cicca	- A 1		3	Bur	K-	D	r	Nilla	mspo	rt mi	21795
	Sta		31. Date filed (Month, Day, Year)	2	strar's Signa	iture								
	Registr	21	APR A F	0000		1.								

			For State Registrer	State of M	Marylan		artment of		nd Mental H	ygiene Reg. No.2	006	29476
	Physicia /Medic		Decedent's Name (First, Middle FRA	e, Last) NKLIN LEE T	ULL				2. Date of I Month 08		Year 2006	3. Time of Death 5:08 PM
	Examin		4a. Facility Name (If not institution UPPER CHESAPEAK	_			4b. City, Town,	or Location of			ty of Death	RD
Ì	Funeral Director		5. Social Security Number 212–56–1442	6. Sex 1 <b>X</b> M 2 ☐ F	Age (In yrs. 53	last birthday) Yrs.	If Under 1 Yea Months Days		4 Hrs. 8. Date of 8 (Month, I		9. Birthp Cour M	lace (State or Foreign stry) ARYLAND
	faryland ebow	or	Usual Residence of Decedent  10a. State 10b. County	RFORD	10c. Cit	y, Town or Lo		PPA			1	0d. Inside City Limits 1 XYes 2 □ No
	death with the Maryland ms 23a or 28a-1 show Ernast Le notified at	Director	10e. Street and Number				10f. Zip Code			10g. Citizen o		
036	ē = =	by Funeral	637 FALCONE  11. Marital Status  1 Never Married 2 Marr 3 Widowed 4 Divorced	12. Was Deceder Armed Force	s? <b>X</b> No				in? (Specify Yes or Puerto Rican, etc.)	No- 14. Ra	ISA ace - Americ lack, White, hity: BLA	etc.
)8/ 21215-0036	d within 72 hogiene.	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4o 5+	or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retir	during most ( ad) AL	·		C SCHO	
Satimore. Maryland	ould be fill Mental H larked oth	To Be	17. Father's Name (First, Middle, GEORGE HENRY TU	ILL, JR				MARG	s Name (First, Midd ARET MATTI	EWS		
ā <b>≥</b> €	and 2 sh leath and m 27 is m		19a. Informant's Name/Relations VANESSA I. TUI			637	FALCONER		JOPPA, MA	ARYLAND	21085	
29	Pages Iment of Hent: If its		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	pecify)	te C	emetery, crer OTON ['] S	sition (Name of natory or other pl.	Y	Date 9/3/06	GROTO		wn, State
<b>⊗</b> 8	permit Department any in		21. Signature of Funeral Service	Licensee Scott - Col	lema		Name and Addi LISA SC 552 LEW	ess of Facility OTT FUI IS STR	NERAL HOMI EET, HAVRI	E. P.A. E DE GRA	CE, M	21078
73 3533 年 8760	2 2 2	dical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. A Her Due to (or a b. Due to (or a c.	line.	uence of):			ardiac or respiratory		e	Approximate Interval Between Onset and Death
) M800	es that the death certifica igned by the attending ph be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal	Ideath 3	Ectopic pregnand Other (specify)	ру			Date of deliver	ry Day Year
S. S. S. S. S. S. S. S. S. S. S. S. S. S	quires that n signed b	þ	Part II. Other significant condition	ons contributing to death	but not resu	ulting in the u	nderlying cause g	iven in Part I.		tobacco use co		e cause of death?
rad   keco	iician: The law requir certificate has been si rector, page 2 should l	Be Completed	25. Was case referred to medical					26 Place		opsy formed?	. Were autoprior to cordeath?	osy findings available inpletion of cause of 2 No
Siorl Sr Vi	ding Phys	Certification; To B	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pendin investig	gation	njury Day Year)	ER/Outpatien 28b. Time of Injury	28c. Inju	her: 4 Nurs iry at ork? Yes 2 N	sing Home 5 Re 28d. Describe			")
	ital or Att urs after d ral Direct		3 Suicide 6 Could at determ	building.	etc. (Specify	/) 	eet, factory, office		City or T	(Street and Nun own, State)		
1	To the Hospital or Attentwithin 24 hours after death To the Funeral Director:	Medicai	29a. Certifier (Check only one)  12 Certifyin Decided Medical 29b. Signature and title of gertifier	g Physicien: To the bes Exeminer: On the basis and manner	of examinal	tion and/or in	restigation in my	opinion death	occurred at the time	and nlace	and due to	the cause/s)
	- S F O		30. Name and address of person	who completed cause of	de de liter	M ) 1 23a) (Type,	DO(	0439	09	Augu	at 3	Day, Year)  CO, 2006
	25 Sta	te	Stephanie 31. Date filed (Month, Day, Year) SEP	Linder 1 2000 32. Refs	900 strar's Signa	ture L	erill Ro	1 1	oppa, Mi	1 71	085	
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Funeral Director    Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Co	2:10 PM  eath  Arundel  country)  cennsylvania  10d. Inside City Limits  1 Yes 2 No  Country?  enerican Indian, hile, etc.
Funeral Director    Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Director   Di	Sirthplace (State or Foreign Country)  Pennsylvania  10d. Inside City Limits 1 □ Yes 2 ☑ No  Country?  •  merican Indian, hile, etc.
19a. Informant's Name/Relationship (Type, Print)  19a. Informant's Name/Relationship (Type, Print)  19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State,  20a. Method of Disposition  1   Burial 2   © Cremation 3   Removal from State  4   Donation 5   Other (Specify)  21. Signature of Feneral Service Licensee  22. Name and Address of Facility John M. Taylor Funer  147 Duke of Gloucester St., Annapolis  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Sequentially list conditions, if any, leading to immediate cause. (Final disease or condition resulling in death)  25a. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	1 ☐ Yes 2 ☑ No  Country?  nerican Indian, hite, etc.
19a. Informant's Name/Relationship (Type, Print)  19a. Informant's Name/Relationship (Type, Print)  19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State,  20a. Method of Disposition  1	nerican Indian, hile, etc.
19a. Informant's Name/Relationship (Type, Print)  19a. Informant's Name/Relationship (Type, Print)  19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State,  20a. Method of Disposition  1	hile, etc.
19a. Informant's Name/Relationship (Type, Print)  19a. Informant's Name/Relationship (Type, Print)  19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, 3395 Davidsonville Road Davidsonville 20a. Method of Disposition  1 Burial 2 © Cremation 3 Removal from State 4 Donation 5 Other (Specify)  21. Signature of Foneral Service Licensee  22. Name and Address of Facility John M. Taylor Funer  147 Duke of Gloucester St., Annapolis  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  15	
19a. Informant's Name/Relationship (Type, Print)  19a. Informant's Name/Relationship (Type, Print)  19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State,  20a. Method of Disposition  1   Burial 2   © Cremation 3   Removal from State  4   Donation 5   Other (Specify)  21. Signature of Feneral Service Licensee  22. Name and Address of Facility John M. Taylor Funer  147 Duke of Gloucester St., Annapolis  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Sequentially list conditions, if any, leading to immediate cause. (Final disease or condition resulling in death)  25a. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	
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Physician / Medical Examiner  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, flam, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	
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d.    Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Continue   Conti	Approximate Interval Between Onset and Death
1 Yes 27 Lo 9 Unknown 9 Unknown	elivery Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute I	To the cause of death?  Probably 4 □Unknown
The property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property o	autopsy findings available o completion of cause of sets 2 No
autopry prior to death?  1 Yes 20 No 1 Yes  25. Was case referred to medical examiner?  1 Yes 2 No 1 O O O O O O O O O O O O O O O O O O	ecify)
27. Manner of Death 1 Naturat 2 Accident 3 Suicide 4 Homicide  28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No  28c. Injury at Work? 1 Yes 2 No  28d. Describe how injury occurred Work? 1 Yes 2 No  28d. Describe how injury occurred Work? 1 Yes 2 No  28d. Describe how injury occurred Work? 1 Yes 2 No  28d. Describe how injury occurred Work? 1 Yes 2 No  28d. Describe how injury occurred Work? 1 Yes 2 No  28d. Describe how injury occurred Work? 1 Yes 2 No  28d. Describe how injury occurred Work? 1 Yes 2 No  28d. Describe how injury occurred Work? 1 Yes 2 No  28d. Describe how injury occurred Work? 1 Yes 2 No  28d. Describe how injury occurred Work? 1 Yes 2 No  28d. Describe how injury occurred Work? 1 Yes 2 No  28d. Describe how injury occurred Work? 1 Yes 2 No  28d. Describe how injury occurred Work? 1 Yes 2 No  28d. Describe how injury occurred Work? 1 Yes 2 No  28d. Describe how injury occurred Work? 1 Yes 2 No  28d. Describe how injury occurred Work? 1 Yes 2 No  28d. Describe how injury occurred Work? 1 Yes 2 No  28d. Describe how injury occurred Work? 1 Yes 2 No  28d. Describe how injury occurred Work? 1 Yes 2 No  28d. Describe how injury occurred Work? 1 Yes 2 No  28d. Describe how injury occurred Work? 1 Yes 2 No  28d. Describe how injury occurred Work? 1 Yes 2 No  28d. Describe how injury occurred Work? 1 Yes 2 No  28d. Describe how injury occurred Work? 1 Yes 2 No  28d. Describe how injury occurred Work? 1 Yes 2 No  28d. Describe how injury occurred Work? 1 Yes 2 No  28d. Describe how injury occurred Nor  28d. Describe how injury occurred Nor  28d. Describe how injury occurred Nor  28d. Describe how injury occurred Nor  28d. Describe how injury occurred Nor  28d. Describe how injury occurred Nor  28d. Describe how injury occurred Nor  28d. Describe how injury occurred Nor  28d. Describe how injury occurred Nor  28d. Describe how injury occurred Nor  28d. Describe how injury occurred Nor  28d. Describe how injury occurred Nor  28d. Describe how injury occurred Nor	
determined determined determined building, etc. (Specify)  4 Homicide determined building, etc. (Specify)  201. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner a (Check only)  202. Certifier (Check only)  203. Certifier (Check only)  204. Certifying Physician: To the basis of examination and/or investigation in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner a control of the date and place.	ac etaled
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Mon	ie to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  MICHAEL FRESOND IIC DEFENSE Inches 4400 Annual Colores  State Registrar  AIIC 3 1 2006	onth, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

			1 - State Registrar	State of Maryland	_	artment tificate			d Mental F		e 200	5 2	9479
	Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, Last)  MARGARET  4a. Facility Name (If not institution, give str	,				ocation of D		. 10	c. County of De	6: ath	ne of Death
7	Funeral Director		828 Federal Hill  5. Social Security Number 6. Sex 309-44-9200 10 N	7. Age (In yrs. las	st birthday) Yrs.	If Under Months		tree	Irs. 8. Date of	Birth Day, Yea 194	9 B	ford  Inhplace (Sicountry)  Vir	ate or Foreign
	the Maryland 28a-f show	Director	MD. Harf  10a. State  MD. Harf  10b. County		Town or Lo	tof. Zip (		reet		100.0	itizen of What C	10	de City Limits Yes 2 No
036	72 hours after death with the Maryland netural; or Items 23a or 28a-f show disal Examilier must be notified at	by Funeral	828 Federal H.  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces?  1  Yes, Give Year or Dates:			ent of His fy Cuban	21154 panic Origin? Mexican, Pu	(Specify Yes or erro Rican, etc.)		United  14. Race - Am Black, Wh  Specify:	Sta	in,
Maryland 21215-0036	be filed within 72 hours ital Hygiene. d other then "netural", event, the Medical Exe	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	cion completed) College (1-4or 5+)	16a. Deced (Give life. L	kind of work OO NOT use	o done du e retired) Offi	ring most of	-		Kind of Business	s/Industry	
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	Sta Registr		30. Name and address of person who been ERIC J. SEIFTER, M. 31. Date filed (Month, Day, Year)  SEP 1 5 2006	107 FA 32. Registrar's Signature	US A	SUM	E 200	) LUT	ERVILLE	MO	21093	3	

State of Maryland / Department of Health and Mental Hygiene 006 29480 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month 1343 Richard September 11 2006 Wenner /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01ney Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Min. | Min. | July 31, 1953 7. Age (In yrs. last birthday) 53 Yrs. 9. Birthplace (State or Foreign **Funeral** 213-64-6381 XXM 2□F Maryland Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Damascus Maryland | Montgomery Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20872 26716 Ridge Road death v Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 le markad other than "natural", or Iter 1 Never Married 2 Married White 1 ☐ Yes 2 X No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter/self employed Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mabel Mongan William Jennings Wenner, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26716 Ridge Road, Damascus, MD 20872 Sandra S. Wenner, wife 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Mount Olivet Cemetery Sept. 15, 2006 permit. Page Department of Important: If any injury or once. Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Keeney and Basford PA Funeral Home 106 East Church St., Frederick, MD Richard E MO0255 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Non-Small Cell Lung Cancer disease or condition resulting in death) Metastatiz /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine ed by the attending physician and detached for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown certificete has been signed by inector, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 2X No 1 Yes 2X No 1 ☐ Yes After this certifice funeral director, the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 (npatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending after death. | Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Direc 4 | Homicide 29a, Certifier 🜠 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Park Banner MO MD060335 September 11,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) rince Philip Drive Paul Banga 31. Date filed (Month, Day, Year) #327 Olney, MD 20832 Prince 18111 State SEP 1 5 2006 Registrar

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r Atte	by th	Certification;	3 Suicide	6 Could not b determined	28e. Place of Inju	ry - At ho	ome, farm, stre	eet, factory	, office		28	Bf. Location (S City or Tox	Street and	Number or F	Rural Ro	ute Number,	
Hospital or	i bell								_								
Hoss 24 ho	completely filled in by the fu	edical	29a. Certifier (Check only one)	1 ☐ Certifying Ph 2 ☐ Medical Exer	nysician: To the best on niner: On the basis of and manner state	examina	wledge, death tion and/or inv	occurred vestigation,	at the time in my opi	e, date and inion, deat	d place, ar h occurre	nd due to the d at the time,	date and p	ind manner a place, and du	s stated e to the	l. cause(s)	
To the within 2	удшоз	Me	29b. Signature and	title of certifier	1			290	. License	number			29d. Date	signed (Mon	nth, Day,	Year)	
	-			p 48	W (			D	548	807			9-	1-00	6		
BA	10		30. Name and add	1	completed cause of de	ath (Item	1 23a) (Type, I	Print)				-2.0	21-				
יוט	Sta	te.	31. Date filed (Mor	AGO/WO	32. Jegistra	r's Signa	10011	St.	20,	1,5bu	114	11/1	1/8	0/			
Я	legistr			SEP 0 5 2	006	رس	5 A										

			1 - For State Registrar	State of M	Maryland / De	epartment of Certificate of	Health and Death	Mental Hy	gien <b>2</b> 0	06	29483
	Physici	an	1. Decedent's Name (First, Middle					2. Date of De Month	eath Day	Year	3. Time of Death
	/Medic	cal	Elizabeth Isab			45 C/2 T		8	30	2006	7:52 A M
	Examir	ier	4a. Facility Name (If not institution Atlantic General	-	r)		or Location of Dea	ıın		ty of Death	
$\alpha$	Funeral		5. Social Security Number	6. Sex 7. A	Age (In yrs. last birthd	Berling  (ay) If Under 1 Year	r If Under 24 Hrs		th	ceste) 9. Birthp	place (State or Foreign entry)
32	Director		218-22-5347	1 ☐ M 2 🛣 F	78 Yrs	Months Days	s Hours Min		5 1927		yland
0	pug *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	r Location					Od. Inside City Limits
	Aaryle f sho	ō	MD Worce		Berlin	Location				1	1 ☐ Yes ¾☐ No
00,	death with the Maryland ms 23a or 28a-f show fri ust be redified at	Director	10e. Street and Number	2261	periin	10f. Zip Code			10g. Cîtîzen ol	f What Cour	
10	h with	i Di	6411 Knoll Hi	1 Dr		21811			USA		
	deat	Funerai	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U.S.	13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (	Specify Yes or No		ace - Americ	
36	s after , or it	by Fu	1 Never Married 2 Mar	ried 1 □ Yes 2 🔀 If Yes, Give	]No	1 ☐ Yes 🎾 No			Spec	Lih 4	
11   35   1937 08/30   300 Maryland 21215-0036	hour turel		3 Widowed 4 Divorced	Year or Dates		ecedent's Usual Occu	ination		16b. Kind of	Business/In	ductor
187 2000 21215-(	nin 72 n "na M. Cris	plet		st grade completed)	(G	ive kind of work done e. DO NOT use retire	e during most of wo	orking	TOD. KING OF	DUSINGS SAIN	oustry
1193 5135 14212	d with giene er tha	Completed	Elementary/Secondary (0-12)	College (1-4o		ookeeping			Munici	pal o	ffice
5  6 301 and 2	e file al Hy d oth	Be	17. Father's Name (First, Middle,	Last)			18. Mother's Na	ime (First, Middle	, Maiden Suma	ıme)	
ය දැදු දැදු yla	ould h Ment warke	2	Leonard Everd				Anna				
11   35   08   36 Marylan	12 sh h and 7 is rr treum		19a. Informant's Name/Relations			ailing Address (Stree					Code)
	1 and Healt Hem 2		Ronald Wiesner/ 20a. Method of Disposition	Husband	20h Place of Di	\$11 Knoll sposition (Name of		Data	Md 218 20c. Location	11 - City or To	own. State
නි ට දි	ages ant of it: If it		1 XBurial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S		• Sunset	rematory or other pla Memorial	Park 9/5	/2006	Berli		
ටටරි : උපට : Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other treumatic event, the Marcal Examination ust be rediffed at once.		21. Signatore of Funeral Service			22. Name and Addr	i	,			
B C C	Depa fmpo any ii		Yanasio	lone Th	ablata 1	08 Willia	ms St. Be	erlin,MD	21811	al IIU	me
- 1			23a Part1. Enter the disease, of shock, or heart failure. List	complications that cause only one cause on each							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition				1				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	s a consequence of):	ns lymp	norte			5	
	LAGIMICI	-	Sequentially list conditions,	b. — Due to (or e	is a consequence of):						
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or Injury that initiated events	Sue to (or a	is a consequence or).						
Ć.	execun n and ial-tra	Examiner	that initiated events resulting in death) Last	c Due to (or a	s a consequence of):						
8760,	cate be executed physician and the burial-transit	dicail		d							
1_1 0	certifica oding ph	Medi	IF FEMALE:					<del>,</del>			
Box	w requires that the death certific been signed by the attending p should be detached for use as i	Physician/Med	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 ☐Ectopic pregnanc	су		I .	ate of delive	ery Day Year
产。	the a the a	ysic	1 ☐ Yes 2 MNo 9 ☐ Unknown	4□Pregnant : 9□ Unknown	at time of death	5 Other (specify)				iona i	ou, rou.
15.0.	requires that the sen signed by th rould be detache		Part II. Other significant condition	ons contributing to death	but not resulting in the	e underlying cause g	rven in Part I.	23e. Did t	obacco use cor	ntribute to th	ne cause of death?
ර හි sp	uires sign Id be	d by						10	Yes 2 □ No	3 🗌 Prob	ably 4 Unknown
55-2-00 broad	s beer	oiete						24a. Was	an 24b.	. Were auto	psy findings available
国の品	Physicien: The lar this certificate has al director, page 2	Completed			-				osy irmed?	prior to cor death? 1 \(\sum \) Yes	npletion of cause of
Vital	intifica	BeC	25. Was case referred to medica examiner?				26. Place of De	1 Yes	2 No	1 1 1 1 9 3	20110
	Physicien: this certific ral director,	Tof	1 ☐ Yes 2 No	and the second second	tient 2 ER/Outpa	tient 3 DOA	ther: 4 Nursing I	Home 5 ☐ Resi	dence 6 □Ot	her (Specif)	<i>(</i> )
	ling P	ion:	27. Manner of Death  1 Natural 5 ☐ Pendir		jury 28b. Time lay Year) 28b. Time	y Wo		28d. Describe	how injury occu	irred	
r Sol	Attending r death. ector: After by the funes	icat	2 Accident investig	not be	nîun. At homo form		]Yes 2 □No	29f Location (	Ctroot and Muse	has as Own	/ Pauta Mumbas
= ≥	after a	ertification;	4 Homicide determ	ined   286. Place of It	njury - At home, farm, etc. <i>(Specify)</i>	street, factory, office	•	City or To	street and Num vn, State)	iber or Hura	l Route Number,
3%	To the Hospital or Attending Physicien: The la within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edicai C	29a. Certifier 1 Certifyir (Check only one) Limited Medical	ng Physician: To the best Examiner: On the basis and manners	of examination and/or	eath occurred at the t r investigation, in my	time, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) and m date and place	nanner as st , and due to	ated. the cause(s)
1	To the within To the comp	Me	29b. Signature and title of certifie	5 MA 13			ise number		29d. Date sign	ed (Month,	
			D / 1/1//	MID		D	00641	20	08/	30/0	6
_	20 5		30. Name d address of person			pe, Print)	00641 ie Ber	lin. Mr	) 010	1.4	
	BA 5		Zeeshan A			way Driv	is is ex		7 218		
	Sta Registr	100	31. Date filed (Month, Day, Year) SEP 0 5		trar's Signature	bode					

DHMH 17 Rev 1/2001

Box 68760,

Division of Vital Records, P.O.

Hemen Shah 31. Date filed (Month, Day, Year) State AUG 3 0 2006 Registrar

c Thomas

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Johnson Dr. Frederick 2. Registrar's Signature

MD 2170)

			101	epartment of Health and No		ene 2006 29485
	Physici /Medie		Decedent's Name (First, Middle, Last)  AGNES G. WARREN		2. Date of Death Month AUGUST	
1	Examir		4a. Facility Name (If not institution, give street and number)  CHARLES COUNTY NURSING & REHABILITATION CENT			4c. County of Death CHARLES
	Funeral Director		5. Social Security Number  212-28-5324  Usual Residence of Decedent  6. Sex 1 M 2 F 78  7. Age (In yrs. last birtho	Months Days Hours Min	8. Date of Birth (Month, Day, DECEMBER 1	9. Birthplace (State or Foreign Country) MARYLAND
	within 72 hours after death with the Maryland ene. than 'naturel', or iteme 23a or 28e-f ehow ha Madigal Examiner must be notified at	ector	MARYLAND CHARLES 10c. City, Town of LA PLATA			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	eath with t	Funeral Directo	10e. Street and Number  5430 HAWTHORNE ROAD  11 Marital Status  12. Was Decedent Ever in U.S.	10f. Zip Code  20646	U	Og. Citizen of What Country?  INITED STATES  14. Race - American Indian,
920	ours after d	þ	11. Marital Status  1 Never Married 2 Married  1 Vidowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 Mo If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Splif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 X No Specify:	o Rican, etc.)	Black, White, etc.  Specify: BLACK
21215-0036	be filed within 72 hours after death with the Marylan ital Hygiene. ed other than "naturel", or Iteme 23a or 28e-1 show event, the Madical Examiner must be notified at	Completed	(Specify only highest grade completed) (C Elementary/Secondary (0-12) College (1-4or 5+)	acedent's Usual Occupation live kind of work done during most of work e. DO NOT use retired) DNANCE WORKER	king	6b. Kind of Business/Industry  FEDERAL GOVERNMENT
N	be filed tat Hygi d other event, I	To Be Co	17. Father's Name (First, Middle, Last)  JOHN HENRY STEPNEY	18. Mother's Nam	ne (First, Middle, M	laiden Sumame)
, Maryland	Ith a	_	WILLIAM R. WASHINGTON / NEPHEW 6289			City or Town, State, Zip Code) HEAD, MARYLAND 20640
<u>m</u>	Page nent o ent: If ury or		1 M Burial 2 ☐ Cremation 3 ☐ Removal from State ST. CHA	crematory or other place) RLES CEMETERY SEPTEM		Oc. Location - City or Town, State  CLYMONI', MARYLAND
Ba	permit. Departrimporte Importe eny Inji		21. Senature of Funeral Sensory I censee  LADIA C. IHANION JOHNSON MO0583	22. Name and Address of Facility  THORNION FUNERAL HOME,  3439 LIVINGSION ROAD, I	NDIAN_HEAD.	
	Crate be executed /Medical Examiners the purial-transit sthe burial-transit	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and the cause of light product of the cause of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product of light product o	- Cancer	or respiratory and	st, Approximate Interval Between Onset and Death
.O. Box 6	The law requires that the death certificate be executed its hes been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
ords, P.	w requires that been signed b should be deta	þ	Part II. Other significent conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did toba	accoluse contribute to the cause of death?
Division of Vital Records,	ysicien: The law re is certificete hes be director, page 2 sh	Completed			24a. Was an autopsy perform	prior to completion of cause of
Zita Zita	sicien: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	1 Out	th Check only one	
ion of	Attending Physicien: or death. ector: After this certifice by the funeral director.	atlon: To	1 Yes 2 No 1 Inpatient 2 ER/Outpater 1 Inpatient 2 ER/Outpater 2. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day Year) Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injury Injur	e of 28c, Injury at	ome 5 ☐ Resider 28d. Describe hov	nce 6 □Other (Specify) w injury occurred
Divis	To the Hospital or Attending Phywithin 24 hours attended to whithin 24 hours attended to the funetel Director: After the completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural Route Number. State)
	To the Hospi within 24 hou To the Funer completely fill	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, of Medical Examiner: On the basis of examination and/of and manner stated.	r investigation, in my opinion, death occur	red at the time, da	te and place, and due to the cause(s)
	T wil		29b. Signature and title of certifier  MD	29c. License number 05545.		d. Date signed (Month, Day, Year)
9	816		30. Name and diffess of person who completed cause of death (Item 23a) (Ty FATTMA Y. HUSSETN. MD. 5625 ATTENT	pe, Print) DWN ROAD SUITE 101	CAMP SDRI	NG, MD 20746
	Sta Registr	-	31. Date filed (Month, Day, Year) SEP 0 1 2006		WALL STATE	20740

		1 - State Registrar			partment of I ertificate of			Reg. No.	inc 201.9		
Physicia /Medic		1. Decedent's Name (First, Middle, Law WILLIAM A.	YOUNG,	SR.			2. Date of D Month SEPTEN		Year 2006 10:28p		
Examin	er	4a. Facility Name (If not institution, gi Union Hospita		)	4b. City, Town, Elktor	or Location of Death			4c. County of Death Cecil		
Funeral Director		213-30-7507	Sex 7. An 126 M 2 ☐ F	ge ( <i>In yrs. last birthda</i> 76 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D July	^{rth} 2 1930	9. Birthplace (State or Fore Country) Maryland		
n the Maryland r 28a-f show modified at	tor	Usual Residence of Decedent  10a. State 10b. County  MD Cecil		10c. City, Town or					10d. Inside City Lin 1⊠Yes 2□		
the 28s	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country?		
23a c	alD	134 Wilson St	•		21913	3		U.S.A	. •		
s 1 and 2 should be filed within 72 hours after death with the if Health and Mental Hygiene. If Health and Mental Hygiene item 27 is marked other than "netural", or items 23a or 28a other treumatic event, the Madical Examinar must be not	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ★ Marned  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces' 1 X Yes 2 ☐ If Yes, Give Year or Dates:	?	3. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	ecify Yes or N Rican, etc.)	o- 14. Rad Bla Specif	ce - American Indian, ick, White, etc.		
ithin 72 ho ne. nen "netur Nedicel I	Completed	15. Decedent's Elementary/Secondary (0-12)		16a. Dec (Gi 5+)	. DO NOT use retire	pation during most of work ad)	ing	16b. Kind of B	lusiness/Industry		
I be filed within ntat Hygiene. ed other than "	Be	6 17. Father's Name (First, Middle, Las Arthur Brown	)	M	ason	18. Mother's Name			ruction me)		
and Ment smarked sumatice	은	19a. Informant's Name/Relationship	(Time Drive)			Anna He	<del>_</del>				
permit. Pages 1 and 1 Dep: rtment of Heelth Important: if item 27 any njury or other tr		Sarah Young  20a. Method of Disposition  1 Burial 2 Cremation 3 [ 4 Donation 5 Other (Speci	(4)	20b. Place of Dis cemetery, co Kent C	O. Box 4 position (Name of rematory or other pla remation	n 9/1	0ate 6/06	Smyrn	- City or Town, State		
Dep Impo		21. Signature of Funeral Pervio. Lice	K)	MOODIO I	To Mest	Cross S	t. Gal	ena, M	en L. Scha D. 21635		
Physician /Medical Examiner		23a. Ranti. Enfer the disease, or consider, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	a. A S  Due to (or as	a consequence of):		ng, such as cardiac o			Approximate Interval Between Onset and Death		
bur be	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):	,						
the death certilicate by the attending physiched for use as the l	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	B□Ectopic pregnanc □ Other (specify) _	у			ite of delivery onth Day Year		
w requires that the de been signed by the a should be detached f	ed by P	Part II. Other significant conditions	contributing to death t	out not resulting in the	underlying cause gr	ven in Part I.		,	tribute to the cause of death		
The law require has been age 2 should	Completed by	CVA, ma	1tiple	/				psy ormed?	Were autopsy findings availa prior to completion of cause death? 1 ☐ Yes 2 ☑ No		
ian: ortifica ctor, p	BeC	25. Was case referred to medical examiner?				26. Place of Death	1 ☐ Yes		1 195 2 EQ 110		
hysic his ce	2	1 Yes 2 No	Hospital: 1 ☐ Inpati	ent 2 R/Outpati	ent 3□ DOA Ott	ner. 4 Nursing Ho	me 5□ Resi	dence 6 Oth	ner (Specify)		
Attending P death. ctor: Atter to	Certification;	27. Manner of Death  1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be determined	e 28e. Place of In	iry Year) 28b. Time Injury jury - At home, farm, s ic. (Specify)	of 28c. Injury	ry at rk? ]Yes 2 □ No	28d. Describe	how injury occur			
or Atterde	린티						,				
	Medical Certi	29a. Certifier 1★ Certifying Pl	nysician: To the best niner: On the basis of and manner st	of my knowledge, de of examination and/or ated.	ath occurred at the tri investigation, in my o	me, date and place, appinion, death occurre	and due to the ed at the time,	cause(s) and ma	anner as stated. and due to the cause(s)		

State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

251 South Bohemia Ave. Cecilton, MD. 21913

W. Bruce Obenshain, M.D. 25

B1. Date filed (Month, Day, Year)

SEP 1 5 2006

SEP 1 5 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) SEP 1 5 2006

			1 - For State Registrar	State of N	Maryland / Depa	artment of		Mental Hy	giene	6 201.07
			1. Decedent's Name (First, Middle, La	st)				2. Date of De	aath 200	3. Time of Death
	Physici /Medi		Dorthea Adalae	Yeado				SEPTER	NBER 4 20	006 7:25P M
	Examir		4a. Facility Name (If not institution, give	street and number	r)	4b. City, Town	, or Location of Dea		4c. County of E	
W.	<u>.</u>		Washington County			Hagers			Washing	
	Funeral		5. Social Security Number 6. S	ex	Age (In yrs. last birthday)  OG  Yrs.	If Under 1 Year Months Day		(Month, Da		Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	7	96 Yrs.			July 1	1,1910 Mi	nnesota
	aryland •how		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Mar	tor	Maryland Washingto	n	Hagerst	own				1 Yes 2 □ No
	ith with the Maryla 23a or 28a-f ehor	Director	10e. Street and Number			10f. Zip Code	•		10g. Citizen of What	t Country?
	hours after death with the Maryland turel; or Iteme 23s or 28s-f show at Examinar nust be notified at	ia i	1011 Oak Hill Ave			21742	2		U.S.A.	
	er dez	Funerai	11. Marital Status	12. Was Deceder Armed Force:	s?	Was Decedent of f Yes, specify Cu	f Hispanic Origin? (s uban, Mexican, Puer	Specify Yes or No to Rican, etc.)	)- 14. Race - A Black, V	American Indian, Vhite, etc.
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ▼Widowed 4 ☐ Divorced	1 □ Yes 2 If Yes, Give Year or Dates	TNo I	1□Yes 2₩N			Specify:	
Ş	ture	edt	15. Decedent's Ed			dent's Usual Occ	unation		16b. Kind of Busine	White
15	nin 72 n nat	Completed	(Specify only highest gra	de completed)	(Give		e during most of wo	rking	160. Kind of Busine	assyndustry
217	d within glene. or then	E	12	College (1-4o		naker			Domestic	
p	e filed wall Hygier other the	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle	Maiden Surname)	
Vai	Ments Ments arked	10	Henry Erwin Mcl	lahan			Miltida	во:	lger	
Maryland 21215-0036	s 1 and 2 should be filed withing theelth and Mental Hygiene. Item 27 is marked other than other traumatic event, the Mental and the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	g Address (Stree	et and Number or R	ural Route Numb	er, City or Town, Stat	e, Zip Code)
	and eelth m 27		Robert J. Yeado	Son					Maryland 2	
Baltimore,	permit. Pages 1 and 2 should be filed Department of Heelin and Mental Hygi Importent: If Item 27 is marked other eny injury or other traumatic event. In ance.		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □	Removal from Stat	e 20b. Place of Dispo	sition (Name of natory or other p	^(ace) 9/07	/2006	20c. Location - City	or Town, State
Ħ.	t. Pa rtmen rtent:		4 □Donation 5 □ Other (Specify		Mt. Calvar	y Catho	licCemete	ry I	Portland,	Oregon
Bal	permit. Pa Departmen Importent: eny injury		21. Signature of Funeral Service Licen	969	22	. Name and Add	Iress of Facility Re	st Haver	Funeral	Chapel
	20204		23a. Part1. Enter the disease, or comp	dications that cause						ryland 21742
	Physician /Medical		shock, or heart failure. List only in the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control o	a	line.	a, \ 4		c or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Examiner				Ancmie					
	B ==	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	b. Due to (or a		.\	- t [	4	. L .	
	nd ransl	Examiner	triat initiated events	c	clostrad.	V m	Difficil	* Co	1, 7,5	
00	ate be executed thy sicien and the burial-transit	Ä	resulting in death) Last	Due to (or a	s a consequence or,	L.				
8760,	ate b	dicai	•	d	malnul	V1 10	~			
P.O. Box 6	The law requires thet the death certificate be execut tite has been signed by the attending physicien and rage 2 should be detached for use as the burial-tran	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Ø No 9 □ Unknown		2 ☐ Fetal death 3 ☐	Ectopic pregnan Other (specify)	су		23d. Date of Month	delivery Day Year
	thet t	A P	Part II. Other significant conditions or	ontributing to death	but not resulting in the ur	derlying cause o	zven in Part I.	23e. Did to	obacco use contribute	e to the cause of death?
sp	uires I sign Id be	d b	chri	nic Obs	tractive	Lung	Discass			Probably 4 Duknown
Ö	w requir been si should	ete	5.1	0.1	thetive idism		717	24a. Was		
Division of Vital Records,				ronyve	10(1)			autop perfo		
Ξ		To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpat	tient 2 ER/Outpatien	3 DOA O	thor	th (Check only o		
o	g Phy er thi		27. Manner of Qeath	28a. Date of In	jury 28b. Time of	28c. Inju			dence 6 Other (S	pecify)
<u>io</u>	ath. r: Aft	atio	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, D	lay Year) Injury		ork? ⊒Yes 2∐No			
<u>×i</u>	ar des	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of It	njury - At home, farm, streetc. (Specify)	et, factory, office	9	28f. Location (S City or Tox	Street and Number or	Rural Route Number,
Ö	rs afte	Cer		building, e	ste. (Opachy)			City of Tou	m, State)	
	To the Hospital or Attending Phys within 24 hours alter death. To the Funerel Director: After this completely filled in by the funeral di	edicai	29a. Certifying Phy (Check only one) 2 Medical Exam	rsician: To the bes iner: On the basis and manner s	t of my knowledge, death of examination and/or inv stated.	occurred at the estigation, in my	time, date and place opinion, death occu	, and due to the cred at the time,	cause(s) and manner date and place, and d	as stated. due to the cause(s)
	To To t	Σ	29b. Signature and title of certifier	and me	hen		nse number		29d. Date signed (Mo	-1 -1
			1			D	006030		07/0	5/86
05	H-0		30. Name and address of person who o	ompleted cause of			11 00	CF	2,740	
	Sta	to.	31. Date filed (Month, Day, Year)		trar's Signature	Ho	squiston,	× × 9	21740	
	Registr		SEP 0.6.20	06	M. A.	1.6.3				

State of Maryland / Department of Health and Mental Hygienes 29488 1 - For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** CKEN FILSWOY coral Sentember 7:00 A 13,2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 11cms) Spital Westmins 11 cms) ent If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months TXXM 2□F Days Hours Director 213-18-0577 86 Yrs 12/3/1919 Indiana Usual Residence of Decedent 10a State 10b. Count 10c. City, Town or Location r than "natural", or Itema 23a or 28a-f show The Medical Exact sermal by notified at 10d. Inside City Limits Maryland Carroll Westminster 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 2204 Cherokee Dr. United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, e filed within 72 hours after d if Hygiene. other than "natural", or item Armed Forces?

XXYes 2 No 1943—
If Yes, Give
Year or Dates: 1946 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes ZENo ģ White Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify onfy highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: if item 27 is marked other tha any injury or other traumatic event, Ite 2008. WR Grace Research Chemist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ellsworth Wilber Acker Lucy Machin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2204 Cherokee Dr. Westminster, MD 21157 Grace C. Acker(wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Parkwood Cemetery 9/18/2006 Parkville, MD 22. Name and Address of Facility
Burrier-Queen Funeral Home and Crematory, P.A. 21. Signature of Funera 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approxi Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ereusi Physician 3 2075 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine to the Hospital or Attending Physician: The law requires that the death certificate be executed -transit and Due to (or as a consequence of) attending physician a for use as the burial-Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death ned by the a 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2- No been si 1 ☐ Yes 3 Probably 4 DUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 1 ☐ Yes 2 ☐ No Division of Vital 1 Yes 2. No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 2 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 1 Natural 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dav. Year) 00059993 cause of death (Item 23a) (Type, Print) 30. Name and address of person who complete 295 MIN 31. Date filed (Month. 32. Registrar's Signature State 2006 Registrar

**ORIGINAL** 

			1- State Registrar Amend Item 20 Maryla	nd/Depa Cei	tificate of	deelth and Death	Mental Hygi	ene g. No 2006	29489
	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of Death Month		3. Time of Death
	/Medi	al	4a. Facility Name (If not institution, give street and number)		4h Cihi Toum	or Location of De	Septem!	4c. County of Deat	*
4	Examir	er	305 Pontiac Avenue		Ral+	i Cocation of De	atn	V/A	n
	Funeral Director		0 1100	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		Year) 9. Birt Co 1925 Ma	hplace (State or Foreign untry) ryland
	and w		Usual Residence of Decedent           10a. State         10b. County         10c.	City, Town or Lo	cation				10d. Inside City Limits
	Maryla a-f sho	tor	Maryland N/A	Baltimo					1 A Yes 2 No
	death with the Maryland ms 23a or 28a-f show	al Director	10e. Street and Number 1 W. Conway Street Apt. 405	)	10f. Zip Code 21	201	10	g. Citizen of What Co	untry?
980	ours after rat', or Ita Examina	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ②Divorced  12. Was Decedent Ever in Armed Forces?  1 □ XY es 2 □ No If Yes, Give Year or Dates: ₩W		Was Decedent of H f Yes, specify Cub	an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
5-0	in 72 hours n°natural', polical Ex	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occup kind of work done OO NOT use retire	oation during most of w	vorking 1	6b. Kind of Business/	Industry
2121	_	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 2 years		oo not use retire thant Mar			Naval Tran	sport
Maryland 21215-0036	s 1 and 2 should be filed withi f Health and Mental Hygiene. itam 27 is markad othar than other traumatic event, Ir.e M	Be	17. Father's Name (First, Middle, Last)  Louis Anuszewski		***************************************		ame (First, Middle, M.		
ary	2 should be and Mental is marked creamatic ever	To	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street		Rural Route Number,		(ip Code)
	and 2 lealth a m 27 ii		Mary Prichard / Niece		ontiac A	venue	Baltimore,		
nore	ages 1 nt of H t: If ita / or ot		1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State		natory or other pla			Oc. Location - City or	
Baltimore,	permit. Pages 1 and Department of Healf Important: If itam 2 any injury or other once.		' 4 □ Donation 5 □ Other (Specify) S  21. Signature - Puneral → rvice Licensee		islaus Co . Name and Addre		Gonce Fune	altimore, eral Servi	
	20 E 9 9		23g Part Enter the dispace or complications that caused the de						gland 21225
	Pnysician		Part 1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line.  Immediate Cause (Final	ath. Do not ente	er the mode or dyir	ng, such as card	ac or respiratory arres	51,	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  a	equence of):					
8	Examiner	<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a cons	acuenco of):					
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause, Cause of Figury that initiated events	equence or,					
60,	cate be executed physician and the burial-transit	al Exa	resulting in death) Last  Due to (or as a cons	equence of):					
68760	tificate ig physi as the l	edical	d.						×
P.O. Box	death cer e attendir d for use	Completed by Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnant in the past 12 months? 4 ☐ Pregnant at time of 9 ☐ Unknown	otal death 3□	Ectopic pregnancy Other (specify)	<u> </u>		23d. Date of deli Month	very Day Year
	w requires that the been signed by th should be detache	d by Pr	Part II. Other significant conditions contributing to death but not r	esulting in the un	derlying cause giv	ren in Part I.	23e. Did toba	cco use contribute to	11
Records,	e law has b	omplete	Atherosclerosis				24a. Was an autopsy performe	prior to c	topsy findings available ompletion of cause of
Vital	ysician: The is certificate director, pag	BeC	25. Was case referred to medical examiner?			26. Place of D	eath (Check only one)		
of	Phys this ral dii	2	1 X yes 2 No Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatient 28b. Time of	3 DOA Oth 28c. Injur	4 🗆 Nursing	Home Signesiden		Niece Mesidence
ion	Attanding Ph r death. actor: After thi by the funeral	atlon	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)	Injury	Wor	yai k? Yes 2 □ No	28d. Describe how	injury occurred	
Division	or Attandi after death. Diractor: A in by the fu	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At building, etc. (Spe	home, farm, stre	et, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
K	To tha Hospital or Attanv within 24 hours after deatl To the Funaral Diractor: completely filled in by the	Medical Ce	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my k 2 Medical Examiner: On the basis of exami and manner stated.	nowledge, death nation and/or inv	occurred at the tire estigation, in my o	ne, date and pla pinion, death oc	ce, and due to the cau	se(s) and manner as e and place, and due	stated. to the cause(s)
<u>v</u>	To tha within 2 To the Complet	Me	29b. Signature and title of certifier		29c. Licens	e number	290	I. Date signed (Month	, Day, Year)
			R. Shreden M.D.		PIS	5905		9/6/06(	September 6, 2006)
			30. Name and address of person who completed cause of death (It	- 3.5		1-0		9/6/06( Baltimore	
	Sta	te.	31. Date filed (Month, Day, Year) 32. Registrar's Sign	Nature of a	roe VA	10 N. G	rene St	saltimore,	NO 91901
	Registr		SEP 1 8 2006 Jane				,		

			1 - For State Registrar	State of Maryland /	Department of Health a		giene 2006	29491
			1. Decedent's Name (First, Middle, Last)			2. Date of Dea	th	3. Time of Death
-	Physic /Medi		Samuel 7	rown		Month September	Day Year	10: 22 P M
1	Exami		4a. Facility Name (If not institution, give s		4b. City, Town, or Location		4c. County of Death	
			Simi Hospital of	Baltimore	Baltimore		MA	
	Funeral		5. Social Security Number 6. Sex	M 2□F 7. Age (In yrs. last b	Months Days Hours	Min (Month Day	Vear) Cou	place (State or Foreign
	Director		Usual Residence of Decedent	/7	Yrs.	3-7-1	1932 Nor	th Carolina
	land bw		10a. State 10b. County	10c. City, Tov	wn or Location			10d. Inside City Limits
	Mary fied	ច្ច	40 4/1	Ral	Limore			1 2 Tes 2 □ No
	with the Maryland a or 28a-f show Lbs notified at	by Funeral Director	10e. Street and Number	17.0	10f. Zip Code		0g. Citizen of What Cou	intry?
	3a or	<u></u>	4117 K. 4 104	1 1	21207		1104	1
	death	Jera	11. Maritat Status	2. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexican	gin? (Specify Yes or No-	14. Race - Amer	
9	or ite	Ē	1 Never Married 2 Married	Armed Forces? 1   Yes 2  No If Yes, Give		i, Puerto Rican, etc.)	Black, White	, etc.
03	hours after turel', or its al Exemin		3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: 1310	ick
21215-0036	72 hc	Completed	15. Decedent's Educ (Specify only highest grade	ation 16a	a. Decedent's Usual Occupation (Give kind of work done during mos	t of working	16b. Kind of Business/I	ndustry
21	in in	du	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)	. or working	-1/	
	filed w Hygier ther th	Ö	12	3 .	supervisor		Stort	2 gout.
p	be fill H d oth	Be	17. Father's Name (First, Middle, Last)	D	18. Mothe	ar's Name (First, Middle, I	Maiden Sumame)	0.11
yla	2 should be and Mental ie marked of sumatic ev	٥	Lee Atris	Brown	tan	nie Mae	Spring.	tield
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hyglene. Item 27 is marked other then "naturel", or items 23a or 28e-f show other traumatic event, Ira Mudical Examinar must be notified at		19a. Informant's Name/Relationship (Typ	e, Print) 19	b. Mailing Address (Street and Number	er or Rural Route Number	City or own, State Zi	Code)
_	l and lealth im 27		Margaret Srow	un Wite	+117 Kathla	nd Alu	Dalto. L	W. 21201
ō	ges to the lift it or of or ot		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Re	moval from State	of Disposition (Name of ery, crematory or other place)	Date	20c. Location - City or T	own, State
tim	tmen tant:		4 ☐ Donation 5 ☐ Other (Specify)	Corr	son Forest Letlan	1-22-2006	Balto. L	d
Baltimore	permit. Pages 1 as Department of Hea Important: If item eny Injury or othe Quce.		21. Signature of Funeral Service License	A-1	22. Name and Address of Facility	Douglass F	uneral S	rvice Pa
	# D = • Ø		Caulfun (	Nacepan	1701 McCull	oh'sti is	alto. M.	21217
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death. Do cause on each line.	not enter the mode of dying, such as	cardiac or respiratory arre	est,	Approximate Interval Between
9	Physician		tmmediate Cause (Finat disease or condition	Museach	1 Infaction			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence	of):			
	LAdiminet		Sequentially list conditions, b.	Coronary	Artery Disease of):			
	± 77 €	lne	Sequentiatly list conditions, if any, leading to initiadiate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	of):			
	The law requires that the death certificate be executed ate has been signed by the attending physicien and the page 2 should be detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence	-0.			
8760,	cien cien buria			Due to (or as a consequence	or);			
87	phys:	dlcai	d.					
9 X	ding	Physician/Med	IF FEMALE:	c. If was outcome of programmy			-	
Вох	ath c	an	23b. Was decedent pregnant in the past 12 months?	<ul> <li>c. If yes, outcome of pregnancy</li> <li>1 ☐ Live birth 2 ☐ Fetal death</li> </ul>			23d. Date of deliv Month	ery Day Year
	the st	yslc	1 Yes 2 No	4□Pregnant at time of death 9□ Unknown	5 Other (specify)		No.	Duy Tour
P.0	thet the d ed by the detached		Part II. Other significant conditions cont	phyting to death but not resulting	in the underlying cause given in Part I	23o Did tob	pacco use contribute to	ha cause of death?
ds,	signed l	j p						
Ö	w requir been si should	etec	Chronic	Renal Insuffici	ency		es 2 No 3 Prol	bably 4 Christian
ě	elaw hast je 2 s	Completed				24a. Was ar autops	y prior to co	ppsy findings available mpletion of cause of
of Vital Records,	The l	S				perform 1 □ Yes 2		2 □ No
/ita	Physician: The this certificeteral director, pag	Be	25. Was case referred to medical examiner?			of Death Check only one	9/	
) <del>_</del>	S S	ို	1/2 163 20110	spitat: 1 Inpatient 2 ER/O	utpatient 3 DOA Other: 4 Nu	rsing Home 5 🗆 Reside	nce 6 Other (Specia	y)
ū	Ing P	Certification:	27. Manner of Death 1 SNatural 5 ☐ Pending		Time of 28c. Injury at Work?	28d. Describe ho	w intury occurred	
sio	tend leath tor: /	cat	2 Accident Investigation 3 Suicide 6 Could not be		M 1 ☐ Yes 2 ☐ I	No		
Division	iter d	Ē	4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office	28f. Location (Str City or Town	reet and Number or Run , State)	al Route Number,
	ral D							
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	Check only 2 Medical Examine	cian: To the best of my knowledger: On the basis of examination ar	e, death occurred at the time, date and/or investigation, in my opinion, deat	d place, and due to the ca	iuse(s) and manner as s	tated.
	the l	Med		and manner stated.		Toolanda at the time, da	ite and place, and ode t	Tile cause(s)
	Son Son	Σ	29b. Signature and title of certifier		29c. License number	29	9d. Date signed (Month,	Day, Year)
	. 1		£, 3	MA	059062	4	September 14	2006
	1401		30. Name and address of person who com	pleted cause of death (Item 23a)	(Type Print)		7	
	IV '		Chad J. Hansen, A.C	2401 W Belved	lere, Baltimore	MO 21215		
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	Kere, Baltimore			
	Registr	ar	CFD 1 8 7	005 Barre L	1. Goeste			
DH	VIH 17 Rev 1/20	001	01 4 0 4	1	-/			

ORIGINAL

	for State Registrar	St	ate of Maryla	-		of Health a <i>of Death</i>	nd Mental I		006	2949
Physiciar	T - le se	Middle, Last)	Henry		Britti	ngham	2. Date of Month	Death	Year 2006	3. Time of Death
/Medica Examine	An et alle all are and a	. •	Henry t and number)		4b. City, To	mgram wm, or Location of altimore	Death	4c. Co	ounty of Death	6:a ^
Funeral Director	5. Social Security Number  215–40–8581  Usual Residence of Decede	6. Sex		s. last birthday) Yrs.	If Under 1 Months	Year if Under 2 Days Hours	Min. (Month	Birth Day, Year)	9. Birthp Coun	olace (State or Foreig ntry) Md.
e Maryland 3a-f ehow	10a. State 10b. Co	ounty NA	10c. C	ity, Town or Lo Balt	imore				1	0d. Inside City Limits 1 X Yes 2 □ No
ath with th	10e. Street and Number 854 Bradhurs	st Rd.			10f. Zip C	ode 1212		10g. Citize	n of What Coun	ntry?
be filed within 72 hours after death with the Maryland hall Hygiene. Id other than "naturel", or items 23a or 28a-f ehow event, the Medical Examinat must be notified at	11. Marital Status  1 Never Married 2  3 Widowed 4 Dive	Married 1	Vas Decedent Ever in tomed Forces?  ☐ Yes 2 ☐ No Yes, Give A Year or Dates:		Was Deceder f Yes, specify 1 ☐ Yes 2	Cuban, Mexican,	in? (Specify Yes or Puerto Rican, etc.)	)	Race - Americ Black, White, Dec <i>ify:</i> B	
Maily Identical Action 2000 of 2 should be filed within 72 hours aft in and Manial Hygiene. It is marked other than "naturel; or traumatic event, the Medical Exam To Be Completed by E	Elementary/Secondary (0 12th grade		n npleted) college (1-4or 5+) Masters	(Give	DO NOT use	done durina most			of Business/Ind	
	17. Father's Name (First, Mi		nry	Britt	ingham		's Name <i>(First, Mid</i> orothy	Marie Marie		Sneed
C = 14 F	19a. Informant's Name/Rela		•				or Rural Route Nu Baltimor		own, State, Zip 212	
Definition of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the most of the	20a. Method of Disposition  1		rai iloiti State	Place of Dispo cemetery, crem			Date 9-18-06		tion - City or To	
permit. Pages Department of important: if i any injury or o	21. Signature of Funeral Se	vice Licensee	Waner	22	. Name and	Address of Facility	Bal	timore,	Md. 2	21202
Physician /Medical	23a. Part1. Enter the disea: shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	e, or complication List only one cal	ns that caused the dea use on each line.  Due to (or as a conse	neta. Do not ent	er the mode of	of dying, such as c		y arrest,	3	Approximate Interval Between Onset and Death
death cartificate be executed  e attending physicien and d for use as the burial-fransit of		b. — c. =	Due to (or as a conse							
death certifi e attending ed for use as	IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1	1 4	yes, outcome of pregr □Live birth 2 □ Fet □ Pregnant at time of □ Unknown	el déath 3 ☐	Ectopic preg			23d	Date of delive	ry Day Year
	Part II. Other significant con	nditions contribu	ting to death but not re	sulting in the ur	iderlying cau	se given in Part I.		_		e cause of death?
ician: The law require certificate hes been sector, page 2 should								utopsy erformed?	prior to com death?	osy findings available npletion of cause of 2 No
, <u>v</u> <del>v</del> <del>v</del> <del>v</del> <del>v</del> <del>v</del> <del>v</del> <del>v</del> <del>v</del> <del>v</del> <del>v</del>	examiner?	Hospit 28 ending	al: 1 ☐ Inpatient 2 ☐ a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury		Other				)
o the Hospital or Attending Phithip 24 hours elter death.  or the Funarei Director: Aler th ompletely filled in by the funeral Medical Certification:	2 Accident in 3 Suicide 6 C 4 Homicide	vestigation ould not be stermined 28	e. Place of Injury - At h building, etc. (Special	nome, farm, stre			28f. Locatio	n (Street and N Town, State)	umber or Rural	Route Number,
the Hospital in 24 hours the Funeral pletely filled	29a. Certifier 1 Cert (Check only 2 Med	icai Examiner: (	t: To the best of my kn On the basis of examination manner stated.	owledge, death ation and/or inv	occurred at restigation, in	he time, date and my opinion, death	place, and due to to occurred at the time	he cause(s) and ne, date and pla	d manner as sta	ated. the cause(s)
To the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the	29b. Signature and title of ce	Triville	1			icense number		29d. Date si	gned (Month, E	Day, Year)
4	30. Name and address of pe	rson who comple	ted cause of death (Ite	m 23a) (Type, I			Ava	BALTI	mere M	d W119
State Registrar	31. Date filed (Month, Day, 1	^(ear) 1 8 2006	32. Registrar's Sign	ature	barte	, , ,				4 4114

			1 - For State Registrar	State of Marylan		rtment of Heal tificate of Dea		ental Hygien	2000	29492
	Physici /Medi Examir	cal	1. Decedent's Name (First, Middle BABY 6.1 4a. Facility Name (If not institution	RL BARI		4b. City, Town, or Loca	<	Date of Death Month Da SEPT IC	Year Year 2006	3. Time of Death 04:480 M
	Funeral Director	A	5. Social Security Number NA	6. Sex 7. Age (In yrs.		If Under 1 Year If U	nore (4 Hrs. 8 burs Min.			lace (State or Foreign
7.75	e Maryland 3a-f show tilled at	ctor	Usual Residence of Decedent  10a. State 10b. County  Md . NA		ty, Town or Loo Baltin		b.		, 10	0d. Inside City Limits 1 X Yes 2 □ No
	h with th	ai Dire	10e. Street and Number 5039 The Alame	-da		10f. Zip Code 21212		10g. Ci	itizen of What Coun USA	try?
980	d within 72 hours after death with the Maryland Jiene. r then "naturel", or items 23a or 28a-1 show the Macinal Examillar must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:	If	Vas Decedent of Hispani Yes, specify Cuban, Me ☐ Yes ※ No Spe	ic Origin? (Specit exican, Puerto Rid ecify:	fy Yes or No- can, etc.)	14. Race - America Black, White, e Specify: Bla	etc.
21215-0036	d within 72 jiene. r then "nai	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) Infant	t's Education st grade completed) College (1-4or 5+)	(Give )	ent's Usual Occupation ind of work done during O NOT use retired)	nost of working	16b. H	kind of Business/Ind	lustry
Maryland	buld be filed Mental Hygi arked other atic event, I	To Be (	17. Father's Name (First, Middle, I Adjeola	Alexander	(	Graves—Bey	Mother's Name (F Troya	First, Middle, Maider	Barbe	er
-	es 1 and 2 sho of Health and f item 27 is my r other traum		19a. Informant's Name/Relationsh  Tonya Fowlkes  20a. Method of Disposition 1   Burial 2 □ Cremation	Aunt  3 □Removal from State	366 Place of Dispos cemetery, crem	atory or other place)		B, Glen Bu		21061
Baltimore	permit. Pag Department Important: I any injury o		4 Donation 5 Other (Sp. 21. Signature of Funeral Service L	Strike Strike Street		m. Pk. Name and Address of F 101 E. Nort		March F.H.		n, Md. 1202
8760,	Physician // Medical Examiner and prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize pr	Ilcai Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence)  c. Due to (or as a consequence)  b. Due to (or as a consequence)  c. Due to (or as a consequence)  d.	MET uence of):  - In buence of):  - ly cu	rthe mode of dying, suc ABOUCATO DOWN Error of Vote deho			aciency	Approximate Interval Between Onset and Death Says  Says
P.O. Box 6	death certific e attending p od for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	I death 3 □I	Ectopic pregnancy Other (specify)			23d. Date of deliver Month	ry Day Year
Records, P.	The law requires that the site has been signed by the bage 2 should be detache.	by	Part II. Other significant conditio	ns contributing to death but not rest	ulting in the un	dertying cause given in F	Part I.		use contribute to the	e cause of death?
tal Rec		e Completed	25. Was case referred to medical	-15		26.0	Place of Death (0	24a. Was an autopsy performed?	prior to corr death?	sy findings available spletion of cause of
Division of Vital	To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director: Atler this certific completely filled in by the funeral director.	Certification: To B	examiner? 1  Yes 2 No  27. Manner of Death 1/2 Natural 5 Pending 2 Accident investig	28a. Date of Injury g (Month, Day Year) ation	ER/Outpatient 28b. Time of Injury	Other	Nursing Home	5 Residence		)
Divi	tal or Att rs after d al Direct ed in by t	Certific	3 Suicide 6 Could n 4 Homicide determi		ome, farm, stre y)	et, factory, office	28f	. Location (Street ar City or Town, State		Route Number,
	the Hospital nin 24 hours a the Funeral in poletely filled	edical	29a. Certifier 12 Certifying (Check only one)	g Physician: To the best of my knot exeminer: On the basis of examinat and manner stated.	wledge, death tion and/or inve	occurred at the time, dat estigation, in my opinion,	te and place, and , death occurred	d due to the cause(s at the time, date and	) and manner as sta d place, and due to	ited. the cause(s)
	To the Within To the comp	Ä	29b. Signature and title of certifier	who completed cause of death (Item  100 3015  32. Registrar's Signar  8 2006		29c. License numl	85	29d. Da	te signed (Month, D	Day, Year)
1	D		30. Name and address of person v SUSAN J. DNLKER	who completed cause of death (Item	1 23a) (Type, P	Place, 1	Saltmon	e, Md.	21200	2
	Sta Registr		31. Date filed (Month, Day, Year)	8 2006 Registrar's Signar	iture	bull				

State of Maryland / Department of Health and Mental Hygiene 29494 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Mary T. Ciscle SEPTEMBER 10:30 AM 2006 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death BALTIMOLE CITY HOSFITAL AGNES If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Sep 28, 19 Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 84 217-22-5021 Yrs Director Maryland Usual Residence of Decedent 10a. State t0h Count 10c. City, Town or Location 10d. inside City Limits ir than "natural", or Iteme 23a or 28a-f ehow the Medical Exeminer must be notified at Maryland Baltimore Catonsville 1 Tyes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 715 Maiden Choice Lane 21228 United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H lant: If fem 27 is marked other. Be George Garrett Carmela Marino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George J. Ciscle / Son 201 Edgevale Road, Baltimore, Maryland 21210 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State permit. Page Department of Important: If any Injury or once. Immaculate Conception 9/19/06 □Denation 5 □ Other (Specify) Towson, Maryland 21 Sign sure of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Staphy 10 coccol One week /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence/of) Examine or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of). Box 68760. Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 2 100 23d. Date of delivery 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown 9 Unknow signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? rohymnias 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X ☐ Inknown 24a. Was an autopsy performed? 1 ☐ Yes 2 XNo 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Colitis 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ္ 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA this After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury death. Il Director: A 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 127541 September 16, 2006 (10ethar Eaga u1) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Beltman, MD-21227 GEETHA RAJA MD, 4367 Holling Form Rd, 31. Date filed (Month, Day, Year) Registrar's Signature State 8 2006 Registrar

MARCY

State of Maryland / Department of Health and Mental Hygien 2006 29495 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 09 **Physician** 48 AM SYNTHIA 06 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FARM BALTO 2820 LODGE ROAD EJGEMERE 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 X F Months Days Hours 217-54-270 56 Yrs. Director MARYLAND Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other then "naturel", or Items 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No BALTO Director mD EDGEMERE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2820 LODGE FARM RUAD 21219 U.S.A Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Amed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: BLACK 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry SCHOOL College (1-4or 5+) Elementary/Secondary (0-12) CUSTODIAN SYSTEM 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CYNTHIA LUTHER OWENS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CYNTHIA OWENS mother 2820 LODGE FARM ROAD BALTO MD 21219 20b. Place of Disposition (Name of cemetery, crematory or other place)

HUNTHILLS MEMCALAL Date 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of h 1 Surial 2 Cremation 3 Removal from State ö permit. Page Department of Important: If eny injury or once. 09-20-06 4 □ Donation 5 □ Other (Specify) BALTO ms 21. Sign of Funeral Service Licensee A2. Name and Address of Fair Funerd 1701 23a. Part1. Enter the disease, or complications that caused the fleath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Breant Cani **Physician** meta tad 0 Ryean disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transit ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy o in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ ate has been sign page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 254No ٩ this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 X Natural 2 ☐ Accident 5 Pending n 24 hours after death.

The Funerel Director: After the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the funct 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 12. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely one) within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) werrach eur 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9114 Philadepelpha -SIVASAILAM Suite 208 31. Date filed (Month, Day, Year) 32. Repistrar's Signature State Registrar 8 2006

		Registrar  1. Decedent's Name (First, Middle,	em State of Ma De Per				2. Date of Dea	th	3. Time of Death
Physici /Medio		Booker Covington					August		
Examin		4a. Facility Name (If not institution, S Bultimore VAM	give street and numbern	enter	- 1	Location of Death		4c. County of [	Death
uneral irector		5. Social Security Number 216–20–4809	5. Sex 7. Age 1M∑M 2□F	(In yrs. last birthd 79	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 06/29/1	9. (, Year) (.927	Birthplace (State or Foreign Country) NC
*		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
el', or items 23a or 28a-f show Examinar must be notified at	to	MD n/a		Baltimore	City				1 <b>∑X</b> Yes 2 □ No
it be rull	Funeral Director	10e. Street and Number 2004 30th Street			10f. Zip Code 21:	218		10g. Citizen of Wha	
	nera	11. Marital Status	12. Was Decedent 8 Armed Forces?	Ever in U.S.	13. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Spe an. Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - A	American Indian, White, etc.
	i by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced		lo	1 ☐ Yes 2 🗓 No			Specify: ]	
	Completed by	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5	(C	ecedent's Usual Occup live kind of work done le. DO NOT use retire	pation during most of workin d)	ng	16b. Kind of Busin	ess/Industry
	Mo	11th	n/a_	*/	VPS	,			al Services
	Be	17. Father's Name (First, Middle, La				18. Mother's Name		Maiden Sumame)	
	ို	George W. Covington  19a. Informant's Name/Relationship	<del></del>	10h M	ailing Address (Street	Hannah Woo		r City or Town Sta	te Zin Code)
ODC9.		Wanda T. Covington			6 N. Linwood				
	3	20a. Method of Disposition		20b. Place of Di	sposition (Name of crematory or other pla	ce) D	ate	20c. Location - Cit	y or Town, State
		1 ☐ Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spe			Forest Vete	ran 09/05/			ls, Maryland
		21. Signature of Funeral Service Li	censee			ess of Facility Wy1			
		23a. Part1. Enter the disease, or co	om lications that caused	the death. Do not		or Street; B	· Parlandina la .		Approximate
		shock, or heart failure. List or Immediate Cause (Final	nly one cause on each lin	10.		rtension	-		Interval Between Onset and Death
an al		disease or condition resulting in death)	a. Due to for as	a consequence of)	2 17 10				
r		Conversion to the sound triang	A ASO1	ration	6				
	iner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of)					
	Examiner	that initiated events resulting in death) Last	c. Due to (or as:	a consequence of):					
	calE			,					
			u		V-2.0				
	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1  Live birth 4  Pregnant at 9  Unknown	2 Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date o Month	f delivery Day Year
	by	Part II. Other significant condition	s contributing to death be	ut not resulting in th	ne underlying cause gn	ven in Part I.		bacco use contribu	ite to the cause of death?
-	Completed						24a. Was autop	sv prio	re autopsy findings available to completion of cause of
								2 No 1 🗆	Yes 2□ No
	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ▼No	Hospital:	nt 2 ER/Outpa	atient 3 DOA Oth	26. Place of Death		ne) lence 6 □Other(	(Specify)
	n: To	27. Manner of Death	28a. Date of Injur	y 28b. Tim	ie of 28c. Inju	4 1 Italishing Flor		ow injury occurred	Specify)
	atlo	1 Natural 5 Pending 2 Accident investiga	ation	11,0		Yes 2 □No			
	Certification:	3 Suicide 6 Could no 4 Homicide determin		ury - At home, farm c. (Specify)	, street, factory, office	4	28f. Location (S City or Tow		or Rural Route Number,
			Physician: To the best of		leath occurred at the ti				
	cal Ce				3				
	edical	(Check only 2 1 3 Medical E	and manner sta	ned.	29n Licon	se number		29d. Date signed (A	Aonth, Day Yearl
	dical	(Check only 2 Medical E		140.	29c. Licens			29d. Date signed (A	
	edical	(Check only 2 1 3 Medical E	Bane	4	AVE	se number 17643		a	Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fh 9859 9-29-06 vt. State of Maryland / Department of Health and Mental Hygiene 2006 29497 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 5PTEMBER 9,2006 12:50F OLEMAN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PALTIMORE TAZ 5. Social Security Number 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)

V/RG/N/A 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 1 F *i*-217-12-0422 Director Jan. 18, 1919 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other then "naturel", or iteme 23e or 28e-f show other treumatic event, the Medical Examinar must be notified at MD 1 Yes 2 No Director ANSDOWNE BALTO CO 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 5th USA AVE 31771 728 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ☐Yes 2 11 No Yes, Give 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0036 Specify: þ 3 ₩idowed 4 Divorced WHITE Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OPERATOR PROCTOR + SILEX 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be 1 Department of Health and Mental I Important: If Item 27 Is marked of WALTER JOYNER PEARL HOGGARD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/060 19a. Informant's Name/Relationship (Type, Print) GLEN BURNIE 1 20c. Location - City or Town, State SON WILLIAM COLE MAN 1711 MARLEY AVE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Defurial 2 □ Cremation 3 □ Removal from State 9-15-06 BALTO. 4 ☐ Donation 5 ☐ Other (Specify) EDAR HILL CEM 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 400/ RITCHIE HWY BALTOMO deron GUNCE FUNERAL SERVICE व्यावया amerou Approximate Interval Between Onset and Death Conset and Death Conset and Death Conset and Death Conset and Death Conset and Death Conset and Death Conset and Death Conset and Death Conset and Death Conset and Death Conse 234 Part 1. Enter the disea or complications that caused the death. Do not enter the shock, or heart failured ist only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) STADY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury 5/0 Due to (or as a consequence of Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit 0 Division of Vital Records, P.O. Box 68760, that initiated events resulting in death) Last Que to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 mopths? 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown cate has been signed by the a page 2 should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 25. Was case referred to medical examiner? 2 No 1 Yes 2 No 1 Yes To the Hospitel or Attending Physician: funeral director Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 TWo 1 Inpatient 2 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 5 🗀 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗀 Homicide within 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of centifier 29c. License number 29d, Date signed (Month, Day, Year) ,200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) X Hano 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2006

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes and All Copies Are Legible.

			For State Registrar		State of Ma	iryland / L	epartm <i>Certific</i>	ent of He ate of D	ealth and N Death	nentai Hyg	giene. Reg. No.	2006	29498
	Physici		1. Decedent's Name (Fi						S	2. Date of Dea	ath ER ^{Da}	3, 20 <b>18</b> 6	3. Time of Death 4:13F M
	/Medic Examin		4a. Facility Name (If not	t institution, aive		Center	4b. C	City, Town, or I	Location of Death	n	4c.	County of Peatr	lmore
Ī	Funeral Director		5. Social Security Numb	3 19	9x 7. Age	(In yrs. last birt	Yrs. If Ur Mon	nder 1 Year ths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Oct 1,	h y, Year) 1929	Coi	nplace (State or Foreign untry) cyland
Vand	MON.		Usual Residence of Dec 10a. State 10	b. County		10c. City, Town	or Location						10d. Inside City Limits
Ma	Ba-f el	Director	MD	Baltimo	ore	1	Baldwi	n					1 ☐ Yes 2√ No
death with the Maryland	a or 2	Dire	10e. Street and Number 4 Harnel (				10f.	. Zip Code	21013		10g. Citiz	zen of What Cor	untry?
	r mus	Funeral	11. Marital Status	Joure	12. Was Decedent E Armed Forces?	Ever in U.S.	13. Was De		panic Origin? (Sp , Mexican, Puerto	pecify Yes or No-		USA 14. Race - Amer	
OUSO Dours after	ral', or ite	by	1 Never Married 3 Widowed 4	_	1 XYes 2 N If Yes, Give Year or Dates:	¹ 48–52		s 2X No	Specify:	r noari, etc.		Black, White	hite
-	Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23s or 28s-1 ehow other traumatic event, the Medical Examiner must be notified at	Completed	15. (Specify of Elementary/Secondar 12	Decedent's Ed only highest grad ry (0-12)	ucation de completed) Coflege (1-4or 5 4		(Give kind or life. DO NO	Jsual Occupat ( work done di T use retired) es mana	uring most of work	king	16b. Kir	nd of Business/I	ndustry unk
א ע פו	d other	Be Co	17. Father's Name (Firs	it, Middle, Last)	<del></del>		Sal		18. Mother's Nam	e (First, Middle,	Maiden	Sumame)	
arylan should be	Menta	ToE	Ray Harris							Harris			
\$ 2	th and 7 is m traum		19a. Informant's Name		•				nd Number or Rui		W &	Town, State, Z	ip Code)
more,	Department of Healt Important: If item 2 eny Injury or other once.		20a. Method of Disposit	tion remation 3 🗆	Removal from State	20b. Place of	Disposition (		Baldwin	Date	20c. Lo	cation - City or 1	Town, State
	Departm Importa eny inju		21. Signature of Funera ROTT	al Selvice Licen	Wade, Die	ctor	State Balti	and Address Anato	s of Facility my Board MD 2120	655 W.	Bal	timore S	Street
P	hysician	1.1	Immediate Cause (Fina	ilure. List only o	olications that caused one cause on each lin	е.	not enter the	mode of dying			rest,		Approximate Interval Between Orsat and Death
	Medical xaminer		disease or condition resulting in death)	(	a	a consequence of							
70	ii.	Iner	Sequentially list condition any, leading to immediate. Enter Underlyin Cause (Disease or injurithat initiated events	ons, ulate	b	i consequence u	d).						
oo/ou,	physician and s the burial-transit	Examiner	that initiated events resulting in death) Last		c. Due to (or as a	a consequence o	of):						
oo/ou,	CD off	edical			d								
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Ords, P	an signed b	ک	Part II. Other significan	nt conditions co	entributing to death bu	ut not resulting in	the underlying	ng cause giver	n in Part I.	23e. Did to	54	1	the cause of death?
	within 24 hours after death.  To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should	Completed								24a. Was a autop perfor	sy	24b. Were aut prior to codeath?	opsy findings available ompletion of cause of
VILE	certifi	o Be	25. Was case referred to examiner?	-	Hospital:	nt 2 ER/Out		Other	26. Pface of Deat				
ion or	th. : After this funeral d	tion: To	27. Mapner of Death	Pending investigation	28a. Date of Injur (Month, Day			28c. Injury Work	→ □ Nursing H	ome 5 Resid			(N)
DIVIS	s after dea it Director of in by the	Certification:		Could not be determined	28e. Pface of Injubul	iry - At home, fai (Specify)	rm, street, fac	ctory, office		28f. Location (S City or Tow	Street and m, State)	d Number or Rui	ral Route Number,
ficsoff e	24 hours	edical (	29a. Certifier (Check only one)	Certifying Phy Medical Exam	vsician: To the best of iner: On the basis of and manner sta	examination and	, death occur d/or investiga	red at the time tion, in my opi	e, date and place, inion, death occur	and due to the dired at the time, d	cause(s) date and	and manner as place, and due	stated. to the cause(s)
Toth	To the comp	M	29b. Signature and title	of certifier				29c. License			29d. Date	signed (Month)	, Day, Year)
			1 Scot	1/ma	nu	M	7 5	DØØ6	2312			1/8/8	06
			30. Name and address	of person who o		ath (Item 23a) (		VE TO	wson, h	MARYLAN	1D 2	1204	
ı	Sta Registr		31. Date filed (Month, -D		00 00 -1-1-1	r's Signature							

			1 - State Amend item#18	State of I	Marylan ,9/18/0	d / Depa 6 TT <i>Cei</i>	artment of rtificate of	Health a	and Me	ental Hyg	giene 20 (	06 29499
Marie Land	Physici /Media		Decedent's Name (First, Middle, L.  DOROTHY	ast)		F	RIEDMAN		2	2. Date of Dea Septem		ear 6.45 AM
	Examir		4a. Fecility Neme (If not institution, gi ROLAND PARK PLA	CE		4	4b. City, Town, BALTIM( If Under 1 Year	ORE				N/A
	Funeral Director			Sex 7 1 M 2 F	Age (in yrs.	last birthday) Yrs.	Months Days		Min.	B. Date of Birth (Month, Day 04/29/1	Year)	Birthplace (State or Foreign Country)  MD
	e Maryland e-f show	ctor	10a. State 10b. County	/A	10c. Cit	y, Town or Lo BALT	cation IMORE					10d. Inside City Limits 1 X Yes 2 □ No
	affer death with the Marylan or Iteme 23s or 28s-f show mitter must be notified at	ral Director	10e. Street and Number 830 W. 40th STR	EET			10f. Zip Code 212:	11		1	og. Citizen of Wha	
5-0036	hours after death with the Maryland tural, or Iteme 23a or 28a-f show al Expiritor must be netitied at	d by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decede Armed Force 1  Yes 2 If Yes, Give Year or Date	s? ⊓No	ŀ	Was Decedent of f Yes, specify Cul		gin? (Speci , Puerto Ri	ify Yes or No- ican, etc.)		American Indian, White, etc.
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	Physician /Medical Examiner		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	polications that cause one cause on each a.  Due no (or	as a consequence of	n. Do not ent right uence of):	Name and Addi 8900 _{de} RE, sucled	STERS	SO LOWN	ROAD _{ry arr}		OS., INC. LE, MDx, 21208 Interval Between onset and Death years  Years
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ou or	ung Phys n. After this funeral di	To B	examiner?  1 Yes 2 No  27. Manne Death  1 Vatural 5 Pending 2 Accident investigator	100		ER/Outpatien 28b. Time of Injury	28c. Inju	her: 4 Nu	rsing Home		ence 6 Other (	Specify)
DIVISION	To the Hospital or Attent within 24 hours efter death To the Funaral Director: completely filled in by the	Certification:	3 Suicide 6 Could not I 4 Homicide determined	286. Place of	Injury - At ho etc. (Specify		eet, factory, office		28	f. Location (Si City or Town		or Rural Route Number,
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	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		29b. Signature and title of certifier  M Harbelle	Macgr	egn	MD	D13	se number 3657	·		9d. Date signed (N Laptemb	e 13,2806
Ì	9			HYREGOL	2, 70	0 W. 4	LOK STA	LEET,	BAL	TIDTOR	E, 1702	-1211
	Sta Registr		31. Date filed (Month, Day, Year) SFP 1.8	2006	Ecas signa	Is A	recti					

			1 - For State Registrar	State of M		epartment of Certificate o		Mental Hy	giene d	2006	2950
	Physic	ian	Decedent's Name (First, Middle, La	st)	C			2. Date of De	eath Day	Year	3. Time of Death
pt.	/Medi		Uscar			rcia		Septemb		2006	06:30 AM
	Exami	ner		opkins Ho	spital	Baltin	, or Location of Deat More Cit	4		unty of Death NA	
	Funeral Director		5. Social Security Number 6. S 485-35-3321	M 2□F	ge (In yrs. last birth 48	Months Day	ar It Under 24 Hrs.	8. Date of Bir (Month, Da 11–25	av. Year)	9. Birthp Cour HO	place (State or Foreign ntry) nduras
	/land		10a. State 10b. County		10c. City, Town	or Location				1	Od. Inside City Limits
	Man 9-fet	ģ	Md. NA		Balt	imore					1 XYes 2 ☐ No
	th the M or 28e-f	Jrec	10e. Street and Number			10f. Zip Code	)		10g. Citizer	of What Cour	ntry?
	death with the Maryland ma 23s or 28s-f show r mast be notified at	ral	238 S. Broadway			2123	31		E	londura	S
21215-0036	atter or ite	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Tyes 2 7 If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cu				Race - Americ Black, White, ecity:	
5-0	"naturel",	Completed by	15. Decedent's Ec (Specify only highest gra	lucation	16a. D	ecedent's Usual Occ	upation	4.1	16b. Kind	of Business/Inc	
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	fled w flygier fler ti	ပိ	12th grade  17. Father's Name (First, Middle, Last)		Un	employed			NA		
Maryland	permit. Pages 1 and 2 should be filed within 72 ho Department of Heelth and Mental Hygiene. Importent: if item 27 is marked other than "natur eny injury or other traumatic event, Ita Mudical ance.	To Be	Esteban		Garcia		18. Mother's Nam	na		Morei	
Mar	12 sh h and 7 ls m reum		19a. Informant's Name/Relationship (			lailing Address (Stree					
	1 and Heelth em 2		Fannie Garcia  20a. Method of Disposition	Neice		O Riverda	le Ave. Ar	Date 3Q,			
пō	ages int of t: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐		cemetery,	crematory or other p				on - City or To	
Baltimore,	artme		4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen		ME. C	armel Cem 22. Name and Add				ılk, Md	•
Ba	Depa Impo		23a. Part1. Enter the disease, or com	ware	<u>ح</u>	1101 E. I	North Ave.		more,	Md. 2	1202
	Physician JMedical Examiner physician and physician and physician and physician and physician sit and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician an	dicai Examiner	shock, or heart failure. List only disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Sepsison and the Due to for as c.	a consequence of):	hìhis				1	Interval Between Onset and Death  Couy S  Month
.O. Box 68	The law requires that the death certificate be executed tie has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 ☐ Ectopic pregnan: 5 ☐ Other (specify)	су		23d.	Date of delive Month	ry Day Year
rds, P	quires that n signed b	þ	Part II. Other significent conditions co	entributing to death be	ut not resulting in th	e underlying cause g	iven in Part I.	23e. Did to	1/		e cause of death?
Vital Records,	The law requirete has been page 2 should	Completed						24a. Was autop perfor		death?	psy findings available inpletion of cause of
/ita	Physicien: this certific ral director,	Be (	25. Was case referred to medical examiner?				26. Place of Deat			10163	20,140
of	Physi this c	ို	1 ☐ Yes 2 No	Hospital: 1 Impatie		Hent 3 DOA		ome 5 Resid	dence 6 🗆	Other (Specify,	)
		ation	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Ďate of Injur (Month, Day	Year) 28b. Time Injur	y Wo	ry at ork? ] Yes 2 ☐ No	28d. Describe h	low infury oc	curred	
	or in b	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	Iry - At home, farm, :. (Specify)	street, factory, office		28f. Location (S City or Tow	Street and Nu m, State)	mber or Rural	Route Number,
	To the Hospital within 24 hours a To the Funeral completely tilled	edicai	29a. Certifier (Check only one) Certifying Phy 2  Medical Exam	rsician: To the best of iner: On the basis of and manner sta	examination and/or	eath occurred at the trinvestigation, in my	ime, date and place, opinion, death occur	and due to the ored at the time, o	cause(s) and date and plac	manner as sta e, and due to	ited. the cause(s)
	With To t	Σ	29b. Signature and title of certifier	10			se number			ned (Month, D	
	2		Pyllampa G	DR, MI)		R	ES-00	0 5	epteml	Der 14	2006
	1		30. Name and address of person who co	e Johns Ha	eath (Item 23a) (Type Skins Hospi	be, Print)	th Walfe St	reet .Rall	imare. N	danilase	21287
6	Sta Registra		31. Date filed (Month, Day, Year)  SFP 1 8 2		's Signature	Coarles				- y - w	And I do